V6.0

STATE OF DELAWARE

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MANAGEMENT SERVICES
1901 N. DuPont Highway
New Castle, DE 19720

REQUEST FOR PROPOSAL NO. HSS-13-012

FOR

DELAWARE MEDICAID ENTERPRISE SYSTEM PROCUREMENT

FOR

Division of Medicaid and Medical Assistance
Lewis Building
1901 North Du Pont Highway
New Castle, DE 19720

Deposit	**Waived**
Performance Bond	**Waived**
Date Due:	***August 7, 2013*** ***11:00 a.m.***

A <u>mandatory</u> pre-bid meeting will be held on June 14,2013, at 9:00 a.m. at the Delaware Health and Social Services, Herman M. Holloway Sr. Campus, Main Administrative Building, 1st Floor Conference Room #198, 1901 N. DuPont Highway, New Castle, DE 19720. All Bidders who wish to bid on this proposal must be present, on time, at the mandatory pre-bid meeting. No proposals will be accepted from Bidders who either did not attend the mandatory pre-bid meeting or who are more than fifteen (15) minutes late. <u>Due to space limitations, it is requested that Bidders limit representation to two (2) individuals. Bidders should RSVP by calling (302) 255-9290 or by e-mailing:</u> DHSS_DMS_DMSprocure@state.de.us.

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MANAGEMENT SERVICES
PROCUREMENT BRANCH
HERMAN M. HOLLOWAY SR. CAMPUS
1901 N. DUPONT HIGHWAY
NEW CASTLE, DELAWARE 19720

V6.0

April 25, 2013

REQUEST FOR PROPOSAL # **HSS-13-012**

Sealed proposals for Delaware Medicaid Enterprise Solution for the Division of Medicaid and Medical Assistance, Lewis Building, 1901 North Du Pont Highway, New Caste, DE 19720 will be received by the Delaware Health and Social Services, Herman M. Holloway Sr. Campus, Procurement Branch, Main Administration Building, Second Floor, Room #257, 1901 North DuPont Highway, New Castle, Delaware 19720, until 11:00 a.m. local time, on August 7, 2013, at which time the proposals will be opened and read. A **mandatory** pre-bid meeting will be held on June 14, 2013 at 9:00 a.m. at Delaware Health and Social Services, Herman M. Holloway Sr. Campus, First Floor Conference Room #198, 1901 N. DuPont Highway, New Castle, DE 19702. For further information concerning this RFP, please contact Nicolette Shuhart at (302) 255-9752.

A brief "Letter of Interest" must be submitted with your proposal. Specifications and administration procedures may be obtained at the above office or phone (302) 255-9290.

Public Notice

Public notice has been provided in accordance with 29 *Del. C*. § 6981.

Obtaining Copies of the RFP

This RFP is available in electronic form [only] through the State of Delaware Procurement Website at http://bids.delaware.gov.

NOTE TO BIDDERS: Your proposal must be signed and all information on the signature page completed.

IMPORTANT: ALL PROPOSALS MUST HAVE OUR HSS NUMBER ON THE OUTSIDE ENVELOPE. IF THIS NUMBER IS OMITTED YOUR PROPOSAL WILL IMMEDIATELY BE REJECTED.

FOR FURTHER BIDDING INFORMATION PLEASE CONTACT:

Kieran Mohammed
Procurement Administrator
DELAWARE HEALTH AND SOCIAL SERVICES
HERMAN M. HOLLOWAY SR. CAMPUS
PROCUREMENT BRANCH
MAIN BLD-2ND FLOOR – ROOM #257
1901 NORTH DUPONT HIGHWAY
NEW CASTLE, DELAWARE 19720
PHONE: (302) 255-9290

Recommended/PTR Business Case Number: 20111736-01-01

This contract resulting from this RFP shall be valid for the period of time as stated in the contract. There will be a ninety (90) day period during which the department may extend the contract period for renewal if needed.

If a Bidder wishes to request a debriefing, he/she must submit a formal letter to the Procurement Administrator, Delaware Health and Social Services, Main Administration Building, Second Floor, (South Loop), 1901 North DuPont Highway, Herman M. Holloway Sr. Campus, New Castle, DE 19720, within ten (10) days after receipt of “Notice of Award.” The letter must specify reasons for request.

IMPORTANT: DELIVERY INSTRUCTIONS

IT IS THE RESPONSIBILITY OF THE BIDDER TO ENSURE THAT ITS PROPOSAL HAS BEEN RECEIVED BY DELAWARE HEALTH AND SOCIAL SERVICES BY THE DEADLINE.

Table of Contents

1 PURPOSE AND OVERVIEW 1
1.1 Introduction 1
1.2 Purpose of this Request for Proposals 1
1.3 Overview: DHSS 2
1.4 Overview: MMIS Replacement Project 2
1.5 Procurement Library 3
1.6 Procurement Contract Person 3
1.7 Definitions 4
2 RFP SCHEDULE 5
2.1 Anticipated Schedule 5
2.2 Letter of Interest 5
2.3 Pre-Bid Meeting 5
3 CONTRACT TERM 6
4 CONTRACTOR RESPONSIBILITIES 7
4.1 Modular Design 7
4.2 Contractor Requirements 8
4.3 Transparency of Subcontractor Relationships 8
4.4 Fiscal Agent Services 8
4.5 Core Medicaid Enterprise Systems Requirements 9
4.6 Point of Sale Pharmacy Benefits Management (POS PBM) Requirements 9
5 PROPOSAL REQUIREMENTS 10
5.1 Instructions 10
5.1.1 Proposal Delivery 12
5.1.2 Closing Date 12
5.1.3 Intent to Award 12
5.1.4 Bidder Questions 12
5.2 Technical Proposal Contents (Disk 1) 12
5.2.1 Table of Contents (Tab 1) 13
5.2.2 Transmittal Letter and Executive Summary (Tab 2) 13
5.2.3 Requirements Checklists (Tab 3) 14
5.2.4 Required Forms (Tab 4) 15
5.2.5 Understanding of the Teaming Approach of the Delaware Medicaid Enterprise System Solution (Tab 5) 15
5.2.6 Corporate Background and Experience (Tab 6) 16
5.2.7 Project Management Oversight and Planning (Tab 7) 17
5.2.8 Technical Approach Instructions 18
5.2.9 Technical Approach to Design, Development, and Testing (Tab 8) 19
5.2.10 Technical Approach to Implementation and Training (Tab 9) 20
5.2.11 Technical Approach to Fiscal Agent Operations (Tab 10) 21
5.2.12 Technical Approach to System Operation and Maintenance Support (Tab 11) 22
5.2.13 Technical Approach to Certification (Tab 12) 23
5.2.14 Management Approach to Contractor Staffing (Tab 13) 23
5.2.15 Technical Approach to Turnover (Tab 14) 27
5.2.16 Technical Approach to Enterprise Architecture (Tab 15) 27
5.3 Cost Proposal Contents (Disk 2) 28
5.3.1 Project Cost Instructions 28
5.3.2 Table of Contents (Tab 1) 28
5.3.3 General Requirements for the Cost Proposal 28
5.3.4 Cost Proposal Pricing Schedules – Attachment K (Tab 2) 29
5.3.5 Software and Hardware Information (Tab 3) 32
5.4 Corporate Confidential Information Disk 3 32

6 EVALUATION OF BID PROPOSALS 34
6.1 Introduction 34
6.2 Evaluation Team 34
6.3 Evaluation of Mandatory Requirements 35
6.4 Evaluation of Bidder Financial Viability 35
6.5 Evaluation and Scoring of Technical Proposals 35
6.5.1 Independent Evaluation of Technical Proposals 35
6.5.2 Evaluation Points for Technical Proposals 36
6.5.3 Description of Evaluation Criteria 37
6.5.4 Technical Approach to System Operation and Maintenance Support 42
6.5.5 Oral Presentations/Site Visits 46
6.6 Evaluation and Scoring of Cost Proposal 46
6.7 Proposal Ranking and Award 47
6.8 The Executive Selection Committee Review Process (Tier 3) 47
6.9 Federal Approvals 47

Attachments

Attachments Table of Contents ..... Attachments TOC-i
A ATTACHMENT A: GENERAL INFORMATION A-1
B ATTACHMENT B: STATEMENT OF WORK B-1
C ATTACHMENT C: DMES FUNCTIONAL REQUIREMENTS C-1
D ATTACHMENT D: DMES SYSTEMS OPERATIONS AND MAINTENANCE TASKS D-1
E ATTACHMENT E: DELIVERABLES E-1
F ATTACHMENT F: GLOSSARY OF TERMS F-1
G ATTACHMENT G: PROCUREMENT LIBRARY G-1
H ATTACHMENT H: CURRENT MMIS TECHNICAL ARCHITECTURE H-1
I ATTACHMENT I: STATE RESPONSIBILITIES AND DMES PROJECT TEAM COMPOSITION I-1
J ATTACHMENT J: DELAWARE MEDICAID BENEFIT PLANS AND WAIVER SERVICES J-1
K ATTACHMENT K: COST PROPOSAL K-1
L ATTACHMENT L: CONTRACT TERMS AND CONDITIONS L-1
M ATTACHMENT M: HIPAA COMPLIANCE MATRIX M-1
N ATTACHMENT N: PERSONNEL – MINIMUM QUALIFICATIONS, ROLES, AND RESPONSIBILITIES N-1
O ATTACHMENT O: CERTIFICATION AND STATEMENT OF COMPLIANCE O-1
P ATTACHMENT P: REQUIREMENTS CHECKLIST P-1
Q ATTACHMENT Q: DELAWARE CONTRACTS DISCLOSURE FORM Q-1
R ATTACHMENT R: BIDDER'S SIGNATURE FORM R-1
S ATTACHMENT S: OFFICE OF MINORITY AND WOMEN BUSINESS ENTERPRISE CERTIFICATION TRACKING FORM S-1
T ATTACHMENT T: BIDDER PROJECT EXPERIENCE T-1
U ATTACHMENT U: DELIVERABLE ACCEPTANCE REQUEST FORM U-1
V ATTACHMENT V: BIDDER CONTACT INFORMATION V-1
W ATTACHMENT W: NAMED STAFF RESUME W-1
X ATTACHMENT X: PERSONAL REFERENCE FORM X-1

1 PURPOSE AND OVERVIEW

1.1 Introduction

This is a Request for Proposal (RFP) for a Delaware Medicaid Enterprise System (DMES) procurement issued by the State of Delaware Department of Health and Social Services (DHSS), Division of Medicaid and Medical Assistance (DMMA).

DMMA is issuing this RFP for the procurement of a new Medicaid Management Information System (MMIS). The new system will be called the Delaware Medicaid Enterprise System (DMES). The State is requesting that a single Contractor, hereafter referred to as "the Contractor" propose and develop a system using a modular design and interoperable enterprise architecture using a collaborative teaming approach.

The State interprets "team" to mean:

- An entity or organization with interdisciplinary or multidisciplinary component groups that share a common goal, each organized for the sole purpose of developing, implementing, and maintaining specific system components or modules, system functionality, or system architecture within the DMES throughout the System Development Life Cycle (SDLC).
- Has unique skill sets and expertise that are independent of other Bidder administrative and non-core business functions or is independently owned and operated by another legal corporate entity.
- The component groups are distinguishable.

The Contractor will also be required to work with DHSS Project Team and technical staff, the State's Independent Verification and Validation (IV&V) Contractor, and any other parties, agents, or contractors chosen by DHSS.

A Data Warehouse/Decision Support System (DW/DSS) is not included as part of this procurement. However, the Bidder will be expected to facilitate the interface between the DW/DSS and the DMES.

1.2 Purpose of this Request for Proposals

Through competitive bids, DHSS intends to procure the Design, Development, and Implementation (DDI) of a new solution along with Fiscal Agent (FA) services to replace the State's aging Medicaid system.

The CMS Seven Conditions and Standards released April 19, 2011, requires an MMIS that embraces a modular framework using a Service Oriented Architecture (SOA).This will lead to greater interoperability and data sharing along with other architecture characteristics that require new development, and the gradual replacement of legacy MMIS around the country. In order for states to receive enhanced federal funding for the replacement of legacy MMIS or enhancements to existing MMIS technology investments they must first comply with the Seven Conditions and Standards set forth by the new CMS policy document. The DHSS will procure a solution that meets the CMS enhanced funding requirements.

1.3 Overview: DHSS

The mission of DHSS is to improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations. DHSS is comprised of 12 divisions as follows:

- Division of Substance Abuse and Mental Health.
- Division of Child Support Enforcement.
- Division of Long Term Care Residents Protection.
- Division of Management Services.
- Division of Developmental Disabilities Services.
- Division of Public Health.
- Division of Services for Aging and Adults with Physical Disabilities.
- Division of Social Services.
- Division of Medicaid and Medical Assistance.
- Division of State Service Centers.
- Division for the Visually Impaired.
- Office of the Chief Medical Examiner.

For further information regarding the Delaware Department of Health and Social Services, go to: http://dhss.delaware.gov/dhss/.

1.4 Overview: MMIS Replacement Project

The State of Delaware, DHSS, and DMMA have issued this RFP to define the State's minimum service requirements, solicit proposals, detail proposal requirements, and outline the State's process for evaluating proposals and selecting a Contractor.

Through this RFP, DHSS seeks to procure the best services at the most favorable, competitive prices and to give all qualified businesses (including those that are owned by minorities, women, disabled, and small business enterprises) the opportunity to do business with the State as vendors and sub-contractors.

The incumbent FA contract extension ends June 30, 2016. Consequently, implementation of the new DMES by July 1, 2016 is of critical importance to DHSS and the State. The Contractor must describe in detail its approach to assure assumption of FA responsibilities without disruption to client care and services or provider payments.

The following project goals are of importance to the State, DHSS:

1. Assumption of operations by July 1, 2016.
2. Assumption of operations without disruption in services or payments.
3. Compliance with the CMS Seven Conditions and Standards.
4. Compliance with the CMS Medicaid Enterprise Certification Toolkit (MECT) requirements.

5. Compliance with the requirements of Title II of the Health Insurance Portability and Accountability Act (HIPAA), including standard code sets such as the International Classification of Diseases and Related Health Problems, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes and International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) procedure codes and the standard transactions such as the Accredited Standards Committee (ASC) X12 Version 5010 and National Council for Prescription Drug Programs (NCPDP) Version D.0 and 3.0. Compliance includes both the Information Technology (IT) portion (i.e., format, syntax, and code set) and the business policy rules (i.e., prior authorization claim adjudication and fraud detection need to use business rules that have been updated for ICD-10).
6. Support the ongoing effort to advance MITA Maturity Levels (MML) for the vast majority of its business processes, including interoperability.
7. Implement processes, tools, and metrics that establish performance measurement benchmarks and improve DHSS's ability to monitor contract performance, vendor performance expectations and accountability, and vendor responsiveness to DHSS requests.
8. Vendor recommendations, which include industry best practices and workflow procedures to support DHSS's continued operation of Medicaid claims processing and administration of the Medicaid program.
9. More convenient and timely online access to system information, procedure manuals, critical documents, and enrollee and provider data for DHSS authorized users and staff.
10. Strategies and methodologies that document a better approach to implementing future initiatives.

1.5 Procurement Library

A procurement library has been established for use by prospective Bidders and DHSS staff during the procurement process. The procurement library contains a number of resource materials that Bidders may find useful in preparing their proposals. A detailed list referencing content and location is included in Attachment G. Procurement Library. DHSS reserves the right to add additional materials to the procurement library at any time until 5 business days prior to the proposal due date.

Procurement library materials will be available onsite at DHSS or available electronically upon request. In order to gain access to the procurement library and system documentation, Bidders must submit a signed Non-Disclosure Agreement. To review onsite resource materials, Bidders must schedule an onsite visit.

1.6 Procurement Contract Person

The contact person for scheduling visits to review material only available onsite may be reached utilizing the following contact information:

Kieran Mohammed – DHSS Procurement Administrator
DE Department of Health and Social Services
Division of Management Services
Procurement Branch, DHSS Campus
Administration Building – 2nd Floor Main Bldg., Room 259

1901 N. DuPont Highway
New Castle, DE 19720
Telephone: (302) 555-1212
Fax: (302) 555-1212
Email: Kieran.Mohammed@state.de.us

A Digital Versatile Disk (DVD-R) of materials in the Procurement Library will also be made available upon request for those Bidders who submit a Letter of Interest. The DVD-R can be requested through the same email listed above.

1.7 Definitions

A glossary of terms and acronyms for words used throughout this document appears in Attachment F.

2 RFP SCHEDULE

2.1 Anticipated Schedule

The following timetable is anticipated for key activities within the procurement process:

Activity	Schedule
State Publishes RFP	May24, 2013
Mandatory Bidder's Meeting and Submission of Letter of Interest	June 14, 2013 09:00 a.m. ET
Submission of Questions	July 1, 2013 04:30 p.m. ET
Response to Questions	July 15, 2013 04:30 p.m. ET
Receipt of Proposals	August 7, 2013 11:00 a.m. ET
Technical Proposal Opening	August 8, 2013 11:00 a.m. ET
Selected Bidder Demonstrations	August 23, 2013
Selected Vendor Site Visits	October 1 through 10, 2013
Selection and Intent to Award (estimated)	November 13, 2013
CMS Approval of Contract	December 23, 2013
Contract Signature	January 24, 2014
Contract Start Date	February 3, 2014
Implementation and Training	May 1, 2016
Operations “Go-Live”	July 1, 2016
CMS Certification	July 1, 2017

2.2 Letter of Interest

Bidders are required to submit a Letter of Interest to bid. This letter will be due by 9:00 a.m. ET on June 14, 2013 and must be hand delivered at the mandatory pre-bid meeting.

2.3 Pre-Bid Meeting

The DHSS will hold a mandatory pre-bid meeting to address questions regarding solicitation procedures only. Attendance is **mandatory** for those firms submitting a bid. Interested Bidders are **required** to complete and submit Attachment V (Bidder Contact Information) at this meeting. The pre-bid meeting will take place on June 14, 2013, 09:00 a.m. ET at the following location:

DHSS Campus
Administration Building
Room 198
1901 N. DuPont Highway
New Castle, DE 19720

3 CONTRACT TERM

The term of this contract is for 5 years with 6 extensions for a possible total of 11 years. Any contract awarded hereunder shall commence on or about February 3, 2014, or date of contract signing if later, and shall remain in effect through June 30, 2024 unless sooner terminated under the provisions of this contract. Each term of the contract shall not exceed 12 months, and shall run from July 1 to June 30 each year. One-year renewals are then permitted to allow a longer contract period. Assuming this contract runs the full 11 years and all annual extensions are used, the contract end date would be June 30, 2024. The extension periods are contingent upon need, State approval, and CMS approval.

4 CONTRACTOR RESPONSIBILITIES

The following are Contractor responsibilities and project requirements under this RFP. Given the limitations of assigning State staff to this project, the Contractor is expected to provide the expertise and provide for the full range of services during the project. Bidders must discuss all requirements in detail in their proposals to acknowledge their responsibilities under this RFP and its attachments. Refer to Attachment I for State Project Team composition.

The Bidder must demonstrate experience and depth in the following areas:

- Experience with data processing and system development for health care claim processing systems and/or health benefit management programs similar in scope to the DMES requirements.
- Has implemented or is in the process of implementing new technology capable of meeting the CMS MECT requirements.
- Experience providing FA services in at least one state or similar experience providing healthcare claims services.
- Has three project references.

This experience is critical in ensuring project success in terms of the future direction of the Department's IT development, as well as maintaining an open partnership with project partners.

4.1 Modular Design

This section describes the State's desire to select a Contractor that will design, develop, implement, manage, and operate the new modular DMES using the following two modular methodologies:

1. **Business Modularity**: The Contractor will provide an approach as defined in Section 1.1 that meets all of the RFP requirements. The Bidder is required to explain the logistics and strategy behind its proposed organizational structure that will optimally serve to meet the requirements of this RFP. The Contractor must perform all of the tasks defined in the Statement of Work (SOW), Attachment B using a collaborative approach. The Bidder is presented with the opportunity to explain each team assembled to address all of the DMES requirements strengths, diversity, depth, experience, and past successes with technological innovation individually and holistically using the proposed approach.

2. **Technical Modularity**: This involves the evaluation of the proposed technical solution in terms of interoperable systems, reusable services, and the use of industry standards for data content and interfaces. The Bidder will have an opportunity to explain and emphasize the use of replaceable components, interoperability, commercial off-the-shelf (COTS) products, and best-of-breed solutions that each team member brings to the project.

The following sections provide the framework and additional high-level information regarding the requirements of the DMES.

4.2 Contractor Requirements

The Contractor is the single entity responsible to the State for all contract and system performance during the project life cycle as well as the coordination of the project teams. The Contractor bears overall project and fiduciary responsibility for meeting project requirements, delivery schedules, and ultimately, Medicaid operations performed on behalf of the State.

The Contractor will be responsible for assembling a project team as discussed in Section 4.1 – Modular Design, 1. Business Modularity, and propose a system architecture that will combine the best-of-breed business solutions and partners to complete and operate the DMES in compliance with the functional business and technical requirements set forth in this RFP. Contractors who elect to use subcontractors are required to describe their alliance with and the strategic role of each business partner (collectively and individually) in assembling the system solution. From the team of business partners identified in the proposal, the Contractor must specifically address the roles and responsibilities of each partner.

4.3 Transparency of Subcontractor Relationships

The Contractor must make its subcontractor agreements available to DHSS and the State upon request. For any subcontract, there must be a designated project manager who is a member of the subcontractor's staff and who is directly accessible by the State. This individual's name and contact information must be provided to the State when the subcontract is executed. The State reserves the right to act as a binding arbiter in any dispute between the Contractor and its subcontractors that may negatively impact operation of the Delaware Medical Assistance Program (DMAP). The State also reserves the right to oversee, manage, coordinate, change, or disagree on any terms of the contract during the term of the contract or subcontractor agreement.

4.4 Fiscal Agent Services

The SOW in Attachment B describes the operational responsibilities for the DMES on behalf of the State. The FA functions include the processing and payment of claims and execution of other financial management functions of the Medicaid program.

The Bidder must propose a team to perform the FA services function as outlined in this RFP and must ensure that it performs to the designated service level agreements (SLAs) in Attachment L established for each business area and as described in a master SLA between the State and the Contractor.

The FA requirements include the resources to manage and operate the following business functional areas as described in Attachment B, Attachment C, and Attachment E of this document:

1. Transaction Processing (HIPAA standard transactions including claims and remittance advices).
2. Financial Management Services (including banking services).
3. Provider Management Services.
4. Client Management Services.
5. Program Integrity Support Services.

6. Web Portal Content Management Services.

4.5 Core Medicaid Enterprise Systems Requirements

The Contractor will provide a team to design, develop, implement, and maintain the Core Medicaid Enterprise System (hereinafter referred to as the Core) as described throughout the various tasks in Attachment B. Functional technical requirements and deliverables associated with the Core are distributed throughout Attachments C, D, and E. The Core will be comprised of associated products and system components that meet the functional and technical requirements of the DMES using the CMS Seven Conditions and Standards modular methodology. The State's goal is to implement a solution using COTS and best-of-breed products to design and assemble replaceable module and system components that require minimal customization and development. The Bidder in its proposal will describe the selection criteria and methodology used in selecting system components and modules for the Core system.

Subsequent to implementation, the Bidder will be required to provide a team to meet the Operations and Maintenance Support requirements detailed in the SOW for both Core and Pharmacy system operations. This team, which is identified in Section 5.2.14 and Attachment N, must work closely with the State to ensure the DMES is running at optimal capacity.

4.6 Point of Sale Pharmacy Benefits Management (POS PBM) Requirements

The POS PBM requirements are designed to deliver associated products that meet the functional and technical requirements (minimal customization needed) defined in Attachment C. The Contractor will provide a team to design, develop, implement, and operate the POS PBM system on behalf of the State as described in Attachment B, Section B.1.23. The POS PBM function also works closely with the State to ensure the systems required to administer the POS PBM program on behalf of the State are running at optimal capacity. It is the State's goal to implement a solution using replaceable COTS and best-of-breed products. Bidders who most effectively meet the State's goal in this category will be awarded added value by the proposal evaluation team. The Bidder, in its proposal, will describe the selection criteria and methodology used in selecting system components and modules for the POS PBM system.

5 PROPOSAL REQUIREMENTS

5.1 Instructions

The proposal must be submitted as follows:

Two (2) original sets of disks (each labeled as “Original”) and six (6) disk set copies (each labeled as “Copy”). In addition, any required confidential financial or audit information relating to the company and not specifically to the proposal may be copied separately as Disk Number 3 (each labeled “Corporate Confidential Information”). Each set of disks will contain:

- Disk Number 1: Technical Proposal (see Section 5.2).
- Disk Number 2: Cost Proposal (see Section 5.3).
- Disk Number 3: Corporate Confidential Information (optional) (see Section 5.4).

Disk Number 1 will contain the following files at a minimum:

- Disk Directory.doc (Microsoft Word 2000 or higher).
- RFP Technical Proposal.doc.
- RFP Technical Proposal.pdf.
- RFP Project Schedule .mpp.

Disk Number 2 will contain the following files at a minimum:

- Disk Directory.doc (Microsoft Word 2000 or higher).
- RFP Cost Proposal.doc.
- RFP Cost Proposal.pdf.

Disk Number 3 will contain the following files at a minimum:

- Disk Directory.doc (Microsoft Word 2000 or higher).
- Corporate Confidential Information.doc.
- Corporate Confidential Information.pdf.

NOTE: Disk Number 2 containing the Cost Proposal must be submitted in a sealed envelope.

The proposals can be submitted in either CD-R or DVD-R formats.

Each proposal file in Portable Document Format (PDF) must be a printable copy of each original disk submitted. Other files may be submitted separately. The Disk Directory.doc file must contain a Word table listing each file contained on the disk along with a short description of each.

It is the responsibility of the Bidder to ensure all submitted disks are machine-readable, virus-free, and are otherwise error-free. Disks (or their component files) not in this condition may be cause for the Contractor to be disqualified from bidding.

The Bid proposal must also be submitted on paper. The following applies to both the Technical Proposal and the Cost Proposal:

1. Bid proposal Materials must be printed on 8.5" x 11" paper.
2. Bid proposal Materials must be double-sided.
3. Bid proposal Materials must be presented in a 3-ring binder (or similar binding which allows for easy removal of documents).
4. Trade secret or other proprietary data must be marked conspicuously on a cover sheet as containing confidential information.

For the paper copies of the Technical Proposal, the Bidder must provide one (1) original and three (3) copies. The original and the copies must be labeled as "Original" or "Copy" as appropriate. The Technical Proposal must be separate from the Cost Proposal.

For the paper copies of the Cost Proposal, the Bidder must provide one (1) original and two (2) copies. The original and the copies must be labeled as "Original" or "Copy" as appropriate. The Cost Proposal must be *sealed* separately from the Technical Proposal.

The disks must be labeled on the outside as follows:

State of Delaware
Department of Health and Social Services
RFP

Delaware Medicaid Enterprise System Procurement
Disk number 1, 2, or 3
Technical Proposal, Cost Proposal, or Corporate Confidential Information

DHSS RFP #HSS-13-012
(Name of Bidder**)**

August 7, 2013

Each Bid proposal package (the paper and disk copies of the Technical Proposal, Cost Proposal, and Company Confidential Information) must be sealed in a box (or boxes).

- The Confidential Information must be sealed in a separate envelope within the box.
- The Cost Proposal must be sealed in a separate envelope within the box.

The packing boxes must be numbered sequentially (e.g., Box 1 of 4, Box 2 of 4). All boxes must contain labels with the following information:

- Bidder's Name and Address.
- Procurement Officer's Name and Department's Address.
- RFP Title and RFP Reference Number.

5.1.1 Proposal Delivery

Proposals must be delivered to:

Procurement Administrator
DE Department of Health & Social Services
Division of Management Services
Procurement Branch, DHSS Campus
Administration Building – 2nd Floor Main Bldg., Room 257
1901 N. DuPont Highway
New Castle, DE 19720

5.1.2 Closing Date

All responses must be received no later than August 7, 2013, 11:00 a.m. ET.

5.1.3 Intent to Award

The proposed mailing date for Bidders to receive notification of "Intent to Award" will be October 15, 2013.

5.1.4 Bidder Questions

DHSS is available to answer Bidder questions only for those that have submitted a letter of interest to bid in accordance with Section 2.2. All questions shall reference the pertinent RFP section(s) and page number(s). Written responses from DHSS will be binding. Other than at the Bidders' meeting, Bidders may not contact any State staff except by sending correspondence electronically to:

Kieran Mohammed
DE Department of Health and Social Services
Kieran.Mohammed@state.de.us

Questions must be received by May 31, 2013, 4:30 p.m. ET. Only those questions received in this manner by this date and time will be considered. It is the Bidder's responsibility to ensure that questions are received by the above named person by the date and time shown above. DHSS will not respond to questions received after that time. A final list of written questions and responses will be posted as an RFP addendum at the following address: http//Bids.delaware.gov.

5.2 Technical Proposal Contents (Disk 1)

The Technical Proposal shall consist of and be labeled with the following sections:

- Table of Contents (Tab 1).
- Transmittal Letter and Executive Summary (Tab 2).
- Requirements Checklist (Tab 3).
- Required Forms (Tab 4).
- Understanding the Teaming Approach of the Delaware Medicaid Enterprise System Solution (Tab 5).

- Corporate Background and Experience (Tab 6).
- Project Management Oversight and Planning (Tab 7).
- Technical Approach to Design, Development, and Testing (Tab 8).
- Technical Approach to Implementation and Training (Tab 9).
- Technical Approach to Fiscal Agent Operations (Tab 10).
- Technical Approach to System Operation and Maintenance Support (Tab 11).
- Technical Approach to Certification (Tab 12).
- Management Approach to Contractor Staffing (Tab 13).
- Technical Approach to Turnover (Tab 14).
- Technical Approach to Enterprise Architecture (Tab 15).

The format and contents for the material to be included under each of these headings is described below. Each subsection within the Technical Proposal must include all items listed under a heading because evaluation of the proposals shall be done on a section-by-section or functional area basis. No reference to, or inclusion of, cost information shall appear in the Technical Proposal or Transmittal Letter.

5.2.1 Table of Contents (Tab 1)

A Table of Contents of the Technical Proposal shall be inserted in Tab 1. The Table of Contents will identify all sections, all subsections contained therein, and the corresponding page numbers. The Table of Contents shall include all sections and subsections present under Tabs 1 through 15. The Table of Contents found at the beginning of this RFP provides a representative example of what is expected for the Technical Proposal Table of Contents.

5.2.2 Transmittal Letter and Executive Summary (Tab 2)

The Transmittal Letter shall be written on the Bidder's official business letterhead stationery and shall be included with each copy of the Technical Proposal. The letter is to transmit the proposal and shall identify all materials and enclosures being forwarded collectively in response to this RFP. The Transmittal Letter must be signed by an individual authorized to commit the company to the statement of work proposed. It must include the following in the order given:

1. A statement acknowledging that the State will not accept any exceptions to the requirements of the RFP, the attachments, and the terms and conditions of the proposed Agreement.
2. A statement that the Bidder acknowledges and understands that alternative or contingent proposals will not be accepted.
3. A statement shall be included indicating the work to be completed by the Contractor and each subcontractor as a percentage of the total work to be performed. The Technical Proposal must not include actual price information. Such inclusion may result in rejection of the proposal.
4. A statement providing the corporate charter number and assurances that any subcontractor proposed is also licensed to work in Delaware.

5. A statement identifying both the Bidder's and its subcontractors' federal tax identification number.
6. A statement of affirmative action that the Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap.
7. A statement identifying all addenda to this RFP issued by the State and received by the Bidder. If no addenda have been received, a statement to that effect shall be included.
8. A statement that the Bidder certifies in connection with this procurement that:
    a. The person signing this letter certifies that he/she is the person in the Bidder's organization responsible for, or authorized to make, decisions regarding the prices quoted and that he/she has not participated, and will not participate, in any action contrary to item (1) above.
    b. If the use of subcontractor(s) is proposed, a statement from each subcontractor on their letterhead must be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor stating:
        i. The general statement of work to be performed by the subcontractor.
        ii. The subcontractor's willingness to perform the work indicated.
        iii. The subcontractor's assertion that it does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap.
    c. The Bidder will not use, or propose to use, any offshore services in fulfilling the requirements outlined in this RFP and in the attached Model Contract.

Tab 2 shall also contain an Executive Summary. The Executive Summary shall present a high-level project description to give the evaluation team and others a broad understanding of the Technical Proposal and the Bidder's approach to this project. This should summarize project purpose, key project tasks, a timeline, deliverables and key milestones, qualifications of key personnel, along with subcontractor usage and their statement of work. A summary of the Bidder's corporate resources, including previous relevant experience, staff, and financial stability must be included. The Executive Summary is limited to a maximum of ten (10) pages.

5.2.3 Requirements Checklists (Tab 3)

Tab 3 shall be labeled Requirements Checklists and will contain:

1. The completed checklist of Mandatory Requirements:

    This checklist will be used to confirm that Bidders have produced and submitted bid proposals according to the RFP specifications. The Bid Proposal Mandatory Requirements Checklist is provided in Attachment P.

2. The completed Requirements Cross-Reference Matrix:

    This checklist will be used to verify the mapping out the location of Bidder responses to the requirements. The Requirements Cross-Reference Matrix is provided in Attachment P.

3. HIPAA Compliance Matrix:

The HIPAA Compliance Matrix must be completed by Bidders to assist DMMA staff in understanding the approach each Bidder takes towards HIPAA compliance. The HIPAA Compliance Matrix is provided in Attachment M.

5.2.4 Required Forms (Tab 4)

This section of the proposal will include the following completed forms:

Certification and Statement of Compliance

Attachment O provides forms in which the Bidder must certify certain required compliance provisions.

Named Position Resume

Attachment W provides the standard format for submitting resumes of key project staff.

State of Delaware Contracts Disclosure

Attachment Q provides a form onto which the Bidder shall list all contracts awarded to it or its predecessor firm(s) by the State of Delaware that have been active during the last 3 years. Failure to list any contract as required by this paragraph may be grounds for immediate rejection of the bid.

Bidders Signature Form

Attachment R contains a standard Bidder's Signature Form.

Office of Minority and Women Business Enterprise Self-Certification Tracking Form

Attachment S is a required self-certification form.

Bidder Project Experience

Attachment T provides a standard form to document the Bidder's work on similar projects.

Bidder Contact Information

Attachment V must be completed, signed, and submitted by prospective Bidders during the pre-bid meeting as described in Section 2.3.

Personal Reference Form

Attachment X provides a standard form for indicating references for proposed staff.

5.2.5 Understanding of the Teaming Approach of the Delaware Medicaid Enterprise System Solution (Tab 5)

In Tab 5, the Bidder shall present its understanding of the DMES solution and the teaming approach.

Due to the complex nature of this procurement, DHSS requests that the Bidder provide a written description of its understanding of the DMES Procurement Project. In this section, DHSS is looking for evidence that the Bidder understands the need to integrate the activities of multiple teams and interface with potentially multiple partners. In addition, it is expected that Bidders will

identify the risks inherent in the overall transition to a new DMES and identify the strategies that the Bidder will use to mitigate each risk. This section should not simply be a reiteration of the scope of services requested in this RFP, but should indicate the Bidder's insight into the full scope and complexity of DHSS's requirements.

5.2.6 Corporate Background and Experience (Tab 6)

Tab 6 shall be labeled Corporate Background and Experience and include the corporate background and experience for the Bidder and each subcontractor as applicable; details of the background of the company, its size and resources; details of corporate experience relevant to the proposed contract service; and a list of all current or recent MMIS or related projects. The specific role of any subcontractor must be identified along with its organizational background and experience to include:

1. Corporate Background: Background information of the corporation, its size, and resources shall cover:
    a. Name of Contractor or subcontractor.
    b. Date established.
    c. Ownership (e.g., public/private company, partnership, subsidiary).
    d. Corporation's Federal Employer's Identification Number (FEIN) and Delaware Corporate Charter Number.
    e. Corporation's primary line of business.
    f. Total number of employees.
    g. Number of personnel engaged in computer systems development and operations.
    h. Number of personnel engaged in MMIS development and operation.
2. Corporate Experience: The details of corporate experience, to include all Medicaid contracts (including subcontractors), within the last 5 years, relevant to the proposed contract. The Bidder shall report its experience in a table that displays the state or place of service, the relevant time frames of execution, and an explanation of the specific service provided to include:
    a. Other government projects of a similar scale.
    b. Experience with large-scale data processing system development (medical claims, MMIS, or otherwise).
    c. Experience with MMIS (indicate clearly which projects demonstrate experience with system design and development, implementation, operation, modification, certification, or turnover).
    d. Experience with multiple benefit plan administration.
    e. Experience with Web portal development and operations.
    f. Experience with encounter data.
    g. Experience working directly with managed care providers, Health Maintenance Organizations (HMOs), etc.
    h. Experience as a fiscal agent or fiscal intermediary.

i. Experience with other health care systems.

3. Bidder Project Experience: For each referenced project, the Bidder and its subcontractors shall provide the following items, one project per page (Attachment T should be included in proposal Tab 4):
    a. Client.
    b. Contact Name and contact information.
    c. Comparable project experience.
    d. Current status.
    e. Original budget.
    f. Completed budget.
    g. Original schedule.
    h. Completed schedule.
    i. Any comments bidder would like to include regarding the project.

Any items listed in this section of the document that the Bidder deems confidential may be included on Disk Number 3 and must be indicated in the response.

5.2.7 Project Management Oversight and Planning (Tab 7)

In Tab 7, the Bidder shall describe its approach to project management and the project management processes it will use to execute and control each project Task. This contract includes both project-based and operations-based activities, each with its own set of requirements and deliverables. The Project Management tasks are described in Attachment B, Section B.1.12 and the Project Management deliverables are outlined in Attachment E, Section E.1.1.

The Bidder must describe how its internal project management approach aligns with the Project Management deliverables identified in Attachment E, Section E.1.1 and also discuss:

1. How it utilizes project management standards and best practices to manage the project:
    a. Project Management Body of Knowledge ® (PMBOK).
    b. Integration Management.
    c. Project Thresholds.
2. The appropriate level and type of management:
    a. Authority of Project Manager.
    b. Maintenance of the Contractor's Project Management Office (PMO) staff.
3. How the Bidder's approach contributes to successful projects that achieve technical and cost objectives.

To support the description of project management, the Bidder shall submit a Project Plan that meets the requirements provided in Attachment E, Section E.1.1 with the proposal. The plan shall describe the activities, processes, and level of effort required to complete the development effort, and include:

1. A Work Breakdown Structure, a Project Schedule, and a Schedule Management Plan detailing the Bidder's approach to managing schedule changes.

2. A Risk Assessment and Response Plan describing the tasks and activities the Bidder will perform as part of its ongoing approach and strategy to the development of options and actions to reduce risks to the project.

3. A Quality Management Plan detailing the Bidder's approach to assuring the quality of the work completed during the project. The Plan shall demonstrate an understanding of DHSS's quality management/oversight activities as well as the Quality Assurance (QA) Contractor's role in those activities as described in Attachment E, Section E.1.1.3.

4. A Staffing Plan in which the Bidder details its approach to staffing the Project to meet DHSS requirements established in Section 5.2.14. This shall include organization and resource loading as well as detailing its Named Staff and their qualifications.

5. A Communications Plan detailing the Bidder's approach to communications between various stakeholders including DHSS, the DMES Project Team, external contractors, and the Bidder's project management staff, including the Bidder's approach to status reporting, deliverables, and problem resolution.

6. A Facilities Plan describing how the Bidder plans to meet the facilities and equipment requirements identified in Attachment B, Section B. 1.11 and the provisioning of facility services and operational functions required to maintain the local facility as described in Attachment E, Section E.1.1.6.

The Bidder must also explain its approach to documenting systems development processes and the tools and controls to be used to ensure a quality DMES development and implementation as part of the project management process. Included in the discussion should be the Bidder's approach to:

1. A Configuration Management Plan.

2. A Software Development Plan.

3. Security Policies and Procedures.

4. A Business Continuity and Disaster Recovery Plan.

5. Use of a Project Repository and System Development Environment.

5.2.8 Technical Approach Instructions

Each task of the contract is described in Tabs 8 through 15, which shall contain the Bidder's approach to the technical requirements of this RFP.

In preparing the response to Tabs 8 through 15, the Bidder shall not simply provide statements that the requirements of the RFP will be met. The Bidder must respond concisely but fully with its approach and how it will comply with the requirements of the RFP. The Bidder must respond to all of the requirements in the RFP, explaining its technical approach, identifying tools to be used, describing staffing commitments, and explaining in detail how it will meet all requirements, as they apply to each task. The Bidder and its subcontractors should address their use of COTS products and Web-based solutions as appropriate in each of the tasks.

5.2.9 Technical Approach to Design, Development, and Testing (Tab 8)

In this section, the Bidder shall describe its approach to completing the tasks described in Attachment B, Section B.1.14, Section B.1.15, and Section B.1.17, and explain its technical approach to the design, construction, and testing of the Core modules and system components of the DMES. Using the requirements contained in this RFP, the Bidder shall articulate its technical approach based on its understanding of the Delaware Medicaid environment and the DMES requirements and deliverables. The Bidder shall address the following elements in its description:

1. The Bidder shall provide a Project Plan with a work breakdown structure, project schedule, and a quality management plan. The proposed Project Plan shall meet the requirements in Attachment E, Section E.1.1.

2. The Bidder shall describe its Software Development approach. The Bidder will present a Software Development Methodology and associated tools used for producing project deliverables that have proven successful on projects of similar size and complexity. The Bidder's development methodology shall address all components of the DMES, including web applications, and shall meet the requirements in Attachment E, Section E.1.3.

3. The Bidder shall address how the Detailed Requirements Analysis will be completed. The Bidder shall describe its approach to design and development activities, deliverable review, and definition of requirements for the new DMES. The Bidder shall describe its approach to construction and quality assurance activities to ensure adherence to design requirements. The Bidder shall discuss its phased development approach and the change and requirements management control processes. The Proposed approach shall meet the requirements in Attachment E, Section E.1.8 and Section E.1.9.

4. The Bidder shall describe its approach to ensuring security standards are met during system development and implementation, as well as system operations and maintenance. The Bidder shall also describe the tools and processes utilized to ensure secure systems, data, and processes.

5. The Bidder shall address quality control in its Project Plan as described in Attachment E, Section E.1.1. The Bidder shall describe its approach to measuring DDI activities involving DHSS, Bidder, and independent quality assurance staff to ensure product quality and adherence to design requirements.

6. The Bidder shall describe its configuration management and control processes, as well as its use of the Project Repository to ensure that project artifacts are current.

7. The Bidder shall describe its approach to testing such that it will ensure that all required functions will meet RFP requirements prior to implementation.

8. The Bidder shall describe its approach to establishing and maintaining interoperability with internal and external systems using open interfaces and demonstrate an understanding of the requirements for interface with other DHSS systems.

9. The Bidder shall describe the staffing resources required to develop detailed design specifications regarding system interface within the Project Plan timeline.

10. The Bidder shall discuss how it will ensure complete identification of the other relevant DHSS systems and interfaces and how the new DMES will be designed and maintained to ensure compatibility with the system interfaces.

11. The Bidder shall demonstrate its preparedness to protect the system against hardware and software failures, human error, natural disasters, and other emergencies, which could interrupt services.

12. The Bidder shall address how it will approach recovery of business functions, business units, business processes, human resources, and the technology infrastructure.

13. The Bidder shall demonstrate its understanding of the system documentation requirements. The Bidder shall submit samples of documents regarding the proposed system for review. Document samples should include portions of user manuals, system narratives, program documentation, data definitions, and performance standards, and should not exceed 200 pages.

14. The Bidder shall address the extent to which the proposed DMES meets HIPAA requirements (specifically, the International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) implementation) that are in effect at proposal submission, and the Bidder's approach to keeping the DMES compliant as HIPAA Rules are enhanced. The Bidder shall provide a list of any COTS products used in the solution.

15. The Bidder will demonstrate its understanding of Operational Readiness Testing preparedness and will specifically address its methodology for validating non-testable requirements.

5.2.10 Technical Approach to Implementation and Training (Tab 9)

Tab 9 shall be labeled Technical Approach to Implementation and Training. This section will include a detailed discussion of the Bidder's approach to preparing the production environment, completing the conversion task, and completing all technical and non-technical training activities to prepare for a successful implementation. The response must address the following:

1. The Bidder shall provide a Project Plan with a work breakdown structure and project schedule describing the implementation, conversion, and training activities involved in this task. The proposed Project Plan shall meet the requirements in Attachment E, Section E.1.1.

2. The Bidder shall describe its technical approach to the implementation of the new DMES, as defined in Attachment B, Section B.1.19.

3. The Bidder shall describe its technical approach to implementing the POS PBM module and component systems as defined in Attachment B, Section B.1.19.

4. The Bidder shall demonstrate its knowledge of data conversion by developing a plan that outlines the conversion task as it relates to size, complexity, resource requirements, testing protocols, and management to ensure a timely and accurate data conversion. The Bidder shall provide a proposed Data Conversion Strategy with the proposal that meets the standard established in Attachment E, Section E.1.15.

5. The Bidder shall describe its experience and approach to developing the training plan. The Bidder shall describe its training approach and the differentiation between the user,

technical, and provider training requirements. The Bidder shall demonstrate an understanding of DHSS and Bidder training staff responsibilities in the training process. The Bidder shall describe its approach to provide for the reusability of training materials and the use of the Project Repository in the training approach. Bidder statements about training expertise, manuals, and visual aids shall be included. Experience and effectiveness of any online training functions shall be described in the proposal. The Bidder shall define its understanding and approach to the creation and use of mocked-up training and testing data that does not include actual names and personal information. The Bidder shall describe the extent to which it has had experience in integrating system training with business process training. The Bidder shall provide a proposed Training Strategy with its proposal that meets the standard established in Attachment E, Section E.1.28.

6. The Bidder shall demonstrate experience in developing online user manuals and desktop procedures for a variety of organizations and applications in multiple media. The Bidder shall describe its approach to development and updating of user manuals that are clear, concise, accurate, and user-friendly and enable users to clearly understand and communicate content effectively as described in Attachment E, Section E.1.19. Bidders are allowed to submit a sample user manual that best represents an example of their work.

7. The Bidder shall demonstrate and describe its understanding and approach to preparing the Implementation Certification Letter including the quality assurance process to assure all of the requirements addressed in the letter have been fulfilled.

5.2.11 Technical Approach to Fiscal Agent Operations (Tab 10)

Tab 10 shall be labeled Technical Approach to Fiscal Agent Operations. The Bidder must operate the DMES and perform all the functions described in this RFP Attachment C, from the date of implementation of each module and system component including the POS PBM, until each function is turned over to a successor fiscal agent at the end of the contract, including any extensions.

The Project requires that certain global business practices and processes be executed consistently across the DMES operational business areas. Such practices include but are not limited to support, deliverable standards, HIPAA compliance, accounting, and auditing requirements. The Bidder must respond concisely but fully with its approach and how it will comply with the Global Business Requirements described in Attachment C and during the SDLC.

1. Attachment C contains the Business and Technical Function requirements of the DMES. The Bidder is expected to describe in this section its proposed solution to meet these business and technical requirements. These requirements include the technical requirements from the CMS MECT checklists. The section also includes operational requirements from the business areas. The Bidder must respond concisely but fully with its approach and how it will comply with all of the requirements in this section of the RFP.

2. The Bidder shall describe its understanding as to the importance of establishing a Quality Management Plan (QMP) for managing and executing operations and as described in Attachment E, Section E.1.35.

3. The Bidder shall discuss its approach to the three (3) key areas of the QMP: quality planning, quality assurance, and quality control. Discussions regarding tools and techniques, quality metrics and measures and established standards, and meeting stakeholder expectations should be included.

4. The Bidder shall discuss its plans for establishing continuous process improvement initiatives that become part of the FA organizational and operating culture and facilitates innovation and operational efficiencies.

5. The Bidder will discuss its approach to producing a staffing capabilities report semi-annually discussing the recruiting and training of new staff, retention and cross-training of existing staff, and opportunities to further align and maximize the efficiency of staffing positions.

6. The Bidder will discuss its approach and understanding of the weekly and annual status reporting requirements.

5.2.12 Technical Approach to System Operation and Maintenance Support (Tab 11)

Tab 11 shall be labeled Technical Approach to System Operation and Maintenance Support. In conjunction with the FA Operation described in Tab 10, the Contractor shall also provide ongoing operation and maintenance (O&M) support for the new DMES. This section will include a detailed discussion of the Bidder's approach to Operations and Maintenance. The Bidder shall:

1. Discuss its understanding of the transition activities that will take place as it relates to moving the overall organization structure from implementation to the support task.
2. Discuss the ongoing management of SOA integration services to include: operation and maintenance of the SOA framework and ESB, management and administration of all open Application Programming Interfaces (APIs), participation on the SOA Governance Committee and the scheduling of meetings as specified by the State, interface definition and inventory, and support team staff identification.
3. Discuss how the POS PBM systems will be maintained over the life of the Contract.
4. Provide details on how the Core DMES modules will be maintained over the life of the Contract.
5. Describe help desk program and staffing, including details on problem identification, escalation, and resolution.
6. Describe the approach to staffing and planning for system modifications, changes, and enhancements, including both software and hardware modifications, and according to the requirements in Attachment D. Include in the description the project management approach and details on how, if at all, it is different from the approach proposed during design and implementation.
7. Discuss the following with regard to the change management process:
    a. Identify the average of the Bidder’s response and resolution times. Provide examples of current measurements and metrics.
    b. Describe the Bidder’s process for providing application fixes and enhancements.
    c. Identify the Bidder’s average turnaround time for fixes and enhancements.

d. Identify the Bidder's anticipated 2014–2021 schedule for new releases and updates if known.

e. Confirm whether the Bidder has User Conferences and/or Advisory Boards.

8. Identify any items that call for the support of the DMES to be different in any way other than that for the POS PBM.
9. Discuss the approach to producing a staffing capabilities report, semi-annually, discussing the recruiting and training of new staff, retention and cross training of existing staff, and opportunities to further align and maximize the efficiency of staffing positions.
10. Discuss the approach and understanding of the weekly and annual status reporting requirements.

5.2.13 Technical Approach to Certification (Tab 12)

Tab 12 shall be labeled **Technical Approach to Certification.** In this section, the Bidder shall describe its approach to ensuring that the DMES meets all federal requirements for certification. The Bidder shall provide a proposed Certification Checklist with the proposal that meets the standard established in Attachment E, Section E.1.39.

The Bidder shall describe its understanding of its role in the certification process, including:

1. The Bidder shall provide a Project Plan with a work breakdown structure and project schedule for the Certification Task. The proposed Project Plan shall meet the requirements in Attachment E, Section E.1.1.
2. Participation in certification planning, preparation, and assembly of review materials.
3. Assisting the State in developing certification presentation materials.
4. Provision of all system outputs needed to demonstrate full functionality from the start of operations.
5. Participation in the federal onsite certification review as necessary.
6. Assistance with answering federal review team questions.
7. Correction of any deficiencies identified during the review within a time period agreed upon between the State and the federal review team.
8. Provision of any additional materials needed to resolve post-review corrective actions.

5.2.14 Management Approach to Contractor Staffing (Tab 13)

It is important that the State understand the staff experience and skills the Bidder is proposing for this project. The Bidder must provide the following items to comply with this section:

1. Staff Skills Matrix.
2. Narratives for the Named Staff.
3. References – three (3).
4. Organizational Charts and Staffing Levels.

The Bidder shall submit a staff skills matrix in its own format to summarize relevant experience of the proposed Named Staff, including any subcontractor staff in the areas of:

- Technical Project Management.
- Business Project Management.

- Account Management.
- Planning.
- System Design and Requirements Analysis.
- System Development.
- Conversion.
- MMIS Implementation.
- Medicaid Operations.
- MMIS Certification.
- Healthcare Claims Processing.

5.2.14.1 Narrative

The Bidder shall provide a narrative description of experience each Named staff member has in the areas relevant to this project. The Bidder will identify if the Named staff member will be subcontracted for this project. Bidder staff requirements will be addressed as described in Attachment N. The narrative must address the experience the person has in the following areas:

1. Experience with Medicaid claims processing systems.
2. Experience with development and operation of large-scale data processing systems.
3. Project management experience.
4. Experience with other medical claims processing systems.
5. Other data processing experience.
6. Degrees and certificates relevant to the position.

The Bidder's Project team will be responsible for performing and supporting the activities described in Attachment B. DHSS requires the Bidder to staff the Project team with Named and Categorized Staff as defined below:

5.2.14.2 Named Staff for Project Management and Control

The Bidder must provide evidence of professional training, academic qualifications, and a proven track record to manage and control large health care implementation projects for each Named Staff position. The Bidder shall describe the project management configuration methodology and tools used to execute and control large projects, and years of experience with PMBOK or Project Management Institute (PMI), or similar project management methodologies as they relate to the DMES project and as understood by the following Managers:

1. Project Director.
2. Project Manager.
3. Deputy Project Manager.
4. Configuration Manager.
5. Quality Control Manager.

5.2.14.3 Named Staff for Design, Development, and Implementation

The Bidder shall identify Named Staff that has experience in developing and managing the phased implementation of large-scale applications, including application development and

testing. The Bidder shall provide the number of years of development and testing experience, knowledge and experience with MMIS, the type and size of applications developed and tested, and experience that demonstrates adherence to project timelines. Named Staff shall have a proven track record and experience in managing the implementation and transition from an existing system to a new system. Named Staff shall have a track record in managing the development and maintenance of all documentation and user manuals. The Bidder shall describe all relevant experience with regard to the following Named Staff positions:

1. Core Medicaid Enterprise Systems Manager.
2. System Implementation Manager.
3. Data Conversion Manager.
4. System and Web Architect.
5. Systems Integration Manager.
6. Testing Manager.
7. Database Administrator.
8. Systems Administrator.
9. Five (5) Sr. Systems Analysts, (Medicaid Subject Matter Experts (SMEs)).
10. Privacy Security Specialist

5.2.14.4 Named Staff for Core Fiscal Agent Operations

The Bidder shall identify Named Staff that has experience, knowledge, and a track record in managing public sector supported health care system FA operations. The general responsibilities and minimum qualifications for these personnel are summarized in Attachment N. The Bidder shall describe relevant operational experience of the Named Staff including: transaction processing to include HIPAA standard transactions for claims and remittance advices, financial management to include banking services, provider management, client management, program integrity support services, web portal content management, and PBM services.

1. Project Director.
2. FA Account Manager.
3. Deputy Account Manager.
4. Provider Services Manager.
5. Claims Operations Manager.
6. Quality Assurance Manager.
7. Pharmacy Manager.

5.2.14.5 Systems Operations and Maintenance Support

The Bidder shall identify Named Staff that demonstrates knowledge and a track record in managing large public sector supported health care system operations and maintenance. The general responsibilities, minimum qualifications, and start date for these personnel are summarized in Attachment N. The Bidder shall describe relevant operational experience of the Named Staff including client support, quality control, document control, process control and change management, and the ability to manage the team to support client-directed system enhancements and system upgrades.

Named Staff for the Systems O&M and Support Sub-Tasks, the Core DMES modules and system components, and POS PBM system components include:

1. Systems Group Manager.
2. Systems Integration Manager.
3. Systems Administrator.
4. Three (3) Senior System Analysts (SMEs).

5.2.14.6 Resumes

Bidders will supply resumes for the Named Staff positions. Resumes will be formatted as outlined in Attachment W. Resumes must show employment history for all relevant and related experience and all education and degrees (including specific dates, names of employers, and educational institutions). Individuals whose resumes are included in the proposal must be available to work on this contract.

5.2.14.7 References

Bidders will supply references for each of the Named Staff positions. References shall include names, positions, phone numbers, and e-mail addresses of a minimum of three clients, within the past 5 years, who can give information on the individual's experience and competence. Attachment X should be included in Tab 4. If the individual has not worked for three different clients in the last 5 years, three references must be provided that can give information on the individual's experience and competence. References must not be from employees of the same company.

5.2.14.8 Organization Chart and Staffing Levels

Each task of the contract is described in Tabs 8 through 14. The Bidder must provide an organization chart that shows all proposed staff for each task of the project. Each major area of the proposed organization and sub-units should be identified. This includes Named Staff, Categorized Staff, and any other proposed staff, including subcontractors, for each task of the project. The total number of full-time equivalent (FTE) personnel for each organizational unit, including subcontractors, should be identified by staff level.

Named Staff – Identify on the chart the major area of responsibility, percent of time dedicated to the DMES project, and location where work will be performed.

Categorized Staff – Identify the job category and FTEs for that position type with in each area or unit.

Subcontractors – Identify on the chart all staff members that are subcontractors. Include the name and location of each sub-contractor position. This organization chart must show how the individual subcontractor entity will be managed by the Bidder. Any sub or co-contractor entity(s) proposed will need prior approval by the State before the contract is signed. If proposing no subcontractors, state in this proposal section: "No subcontractors are being proposed as part of this contract." Refer to Attachment L for subcontractor standards.

5.2.14.9 Categorized Staff

The composition of the Categorized Staff will be at the Contractor's discretion, with exception of the DHSS stated minimum requirements for O&M staff.

5.2.15 Technical Approach to Turnover (Tab 14)

Tab 14 shall be labeled **Technical Approach to Turnover** and include a detailed discussion of the Bidder's approach to the Turnover Task. The response must address these components:

1. Approach to Planning:
    a. General Planning with State.
    b. General Planning with Successor.
2. Approach to developing the Turnover Plan.
3. Approach to developing the DMES Requirements Statement.
4. Approach to providing Turnover Services:
    a. Cooperation with Successor.
    b. Turnover of Archived Materials.
5. Contract Closeout Services:
    a. Financial Reconciliation.
    b. Written Assessment of Contract Performance.
    c. Resolution of Turnover Issues.
6. Approach to Contractor Responsibilities, including:
    a. Contractor staffing.
    b. Contractor facilities.
    c. Contractor resources.
    d. Turnover of DMES.
    e. Turnover of system documentation.
    f. Turnover training.
    g. Facilitation of successor acceptance testing.
    h. Final turnover of up-to-date system, data, paper files, and documentation.

The Turnover Task describes the activities relating to the turnover of the system and business activities at the end of the Contract period to the State or the State's designated Contractor. The task officially starts 12 months prior to the end of the Contract. The Bidder should describe its understanding, approach, and experience with the turnover tasks. The requirements for the Turnover Task are detailed in Attachment B, Section B.1.24.

5.2.16 Technical Approach to Enterprise Architecture (Tab 15)

The Technical Architecture Approach is designed to assess the Bidder's approach to enhancing or changing the Base System architecture, over and above what the Bidder described in response to Section 5.2.5.

1. The Bidder shall describe its understanding of the hardware and software required to support the new DMES, the methodology to be used to define hardware and software capacity, and performance requirements to meet the requirements for the new DMES.

The Bidder shall describe its understanding and approach to meeting the State's database support responsibilities and deliverables. The Bidder shall describe its approach to meeting DHSS's Web service access requirements described in Attachment C, Section C.5.3.1.

2. The Bidder shall describe its understanding and approach to keeping the DMES technology current during the Contract period for all modules and system components including architecture, software, hardware, and updates to COTS and add-on components.

3. The Bidder shall describe its approach to building and deploying an SOA using COTS and Web-based products as architectural components. These products include, but are not limited to rules engines, workflow engine and documentation management system, EDI, and Web portal.

4. The Bidder shall discuss its understanding and approach as it relates to each of the Seven Conditions and Standards in the CMS "Enhanced Funding Requirements: Seven Conditions and Standards" Medicaid Information Technology (IT) Supplement (MITS-11-01-v1.0).

5. The Bidder shall discuss its understanding and approach as it relates to the State's s IT Standards.

5.3 Cost Proposal Contents (Disk 2)

Bidders shall propose a firm fixed price for each of the requirements contained on the pricing schedules within this section. All Pricing Schedules provided in Attachment K shall be submitted as part of the Cost Proposal. No cost information shall be included in the Technical Proposal.

5.3.1 Project Cost Instructions

The Cost Proposal shall include the following:

1. Table of Contents (Tab 1).
2. Project Cost Forms, Pricing Schedules A through F (Tab 2).
3. Software and Hardware Information (Tab 3).

5.3.2 Table of Contents (Tab 1)

A Table of Contents of the Cost Proposal shall be inserted at Tab 1. The Table of Contents will identify all sections (identified herein by Tabs), subsections contained therein, and corresponding page numbers. The Table of Contents shall include all sections and subsections present under Tabs 1 through 3. The Table of Contents found at the beginning of this RFP provides a representative example of what is expected for the Cost Proposal Table of Contents.

5.3.3 General Requirements for the Cost Proposal

5.3.3.1 Total Delaware Medicaid Enterprise System Planning, Design, Development, Testing, and Implementation Price

The total price for System Planning, Design, Development, Testing, and Implementation from Contract Award through June 30, 2016 will include the combined sums of all activities to

complete RFP requirements. The Contractor will be paid according to the payment terms in Attachment L.

5.3.3.2 Operations Price

The pricing schedules prepared for DMES operation shall include all prices for all activities associated with the operation and modification of the system after the operational task begins. The resulting firm fixed price per month (the sum of Pricing Schedule C and Schedule E, Line 2, Columns B through F) will be paid upon receipt of approved invoices from the Contractor.

5.3.3.3 Signature Block

Where a signature block is indicated, pricing schedules must be signed and dated by an authorized corporate official.

5.3.4 Cost Proposal Pricing Schedules – Attachment K (Tab 2)

The Bidder shall complete the Pricing Schedules provided Attachment K.

In completing the pricing schedules, rounding should not be used. A total must equal the sum of its details/subtotals; a subtotal must equal the sum of its details.

The Total Cost shown in Schedule A must include all costs (except out year costs) that the selected Contractor will be paid by DHSS. If specialized hardware or software will be provided by the Contractor, it must be included as a deliverable in this schedule.

Cost information must only be included in the Cost Proposal. No cost information should be listed in the Technical Proposal.

The requirements and schedules, which can be found in Attachment K of this document, are:

1. Summary of Total Proposal (Pricing Schedule A).
2. DMES/POS PBM System Planning, Design, Development, Testing, and Implementation Price Components from Contract Award Through June 30, 2016 (Pricing Schedule B and D).
3. DMES/POS PBM System Planning, Design, Development, Testing, and Implementation Milestone Payments (Pricing Schedules B-1 and D-1).
4. DMES/POS PBM Operational Price Summary (Pricing Schedules C and E).
5. DMES/POS PBM Operational Price Components (Pricing Schedules C1-C5 and E1-E5).
6. Staffing Rate Card (Schedule F).

Bidders must use the required formats for the pricing schedules that are included as Attachment K in preparing their Cost Proposals.

5.3.4.1 Pricing Schedule A – Summary of Total Proposal

1. Line 1 presents the Bidder price for the DMES Planning, Design, Development, Testing, and Implementation Certification activities.

2. Line 2 presents the Bidder price for the POS PBM System Planning, Design, Development, Testing, and Implementation Certification activities

3. Line 3 presents the Bidder DMES Operational Price.

4. Line 4 presents the Bidder POS PBM Operational Price.

5. Line 5 presents the Total Contract Price.

5.3.4.2 Pricing Schedule B and D – System Planning, Design, Development, Testing, and Implementation Price Components from Contract Award through June 30, 2016

Pricing Schedule B and D shall include the total cost components of DMES Planning, Design, Development, Testing, Implementation, and Certification defined by the requirements in this RFP, from contract start February 3, 2014 through June 30, 2016.

Instructions for completing Pricing Schedule B and D:

1. Bidders are required to furnish detailed price information used in deriving the proposed price for each of the categories and subcategories shown on the detailed Pricing Schedule B and D. The total price on Pricing Schedule B and Pricing Schedule D shall be allocated to Pricing Schedule B-1 and D-1 respectively using the percentages shown on each line.

2. Bidders are required to indicate the specific number of full-time equivalent personnel in each of the subcategories and the average hourly rate of pay including benefits on Lines 1a-1m. The prices shown on the schedules are to be the total annual salary and benefits necessary for this task of the contract. The number of specific levels of personnel and their associated prices must agree with the work effort and staffing levels proposed in the Technical Proposal.

3. Bidders are required to include telephone prices for equipment and line charges, including toll free lines.

4. If a price category is not already shown on Schedule B and Schedule D, Line 1 through Line 8, Bidders are to indicate the category under the section headed Other, Line 9. Bidders should list any subcontractor amounts under the section headed Other, Line 9.

5.3.4.3 Pricing Schedules B-1 and D-1 –System Planning, Design, Development, Testing, and Implementation

Pricing Schedules B-1 and D-1 present the prices from Schedule B and Schedule D respectively, Price Components. The total of Line 10, Column C must equal the total of Line 10, Pricing Schedule B.

The Bidder shall compute the total System Planning, Design, Development, Testing, and Implementation price for each milestone by multiplying the percentages in Column B by the total of Line 10, Pricing Schedule B and Pricing Schedule D respectively.

The Total price from Pricing Schedule B-1, Line 10, and Column C shall be entered in Pricing Schedule A, Line 1. The Total price from Pricing Schedule D-1, Line 10, and Column C shall be entered in Pricing Schedule A, Line 3.

5.3.4.4 Pricing Schedules C and E – Operational Prices

Pricing Schedule C and E are a summary of prices for all operational costs, presented in the State fiscal years from July 1, 2016, through June 30, 2021. The 5-year total from Schedule C and Schedule E, Column G shall be entered on Schedule A, line 2 and line 4 respectively.

5.3.4.5 Pricing Schedules C-1 through C-5 and E-1 through E-5

Instructions for completing Pricing Schedules C-1 through C-5 and E-1 through E-5 are as follows:

1. Bidders shall propose a firm fixed price per month for the contract period. The monthly price will include all costs associated with the operation of the DMES described in the requirements of this RFP (except pass through costs as described in Attachment C, Section C.4.3).

2. Bidders are required to furnish detailed price information each of the categories and subcategories shown on the detailed Pricing Schedules C-1 through C-5 and E-1 through E-5. The Total Price This Year, Line 10 on Schedules C-1 through C-5, is to be reported in Line 1, Columns B through F of Pricing Schedule C. The Total Price This Year, Line 10 on Schedules E-1 through E-5, is to be reported in Line 1, Columns B through F of Pricing Schedule E.

3. Bidders are required to indicate the specific number of FTE personnel in each of the subcategories and the average hourly rate of pay including benefits on Lines 1a-1m. The prices shown on the schedules are to be the total annual salary and benefits necessary for the operation of the DMES system. The number of specific levels of personnel and their associated prices must agree with the work effort and staffing levels proposed in the Technical Proposal.

4. Bidders are required to include telephone prices for equipment and line charges, including toll free lines.

5. If a price category is not already shown on Schedules C-1 through C-5, Line and Schedules E-1 through E-5, 1 through Line 8, Bidders are to indicate the category under the section headed Other, Line 9. Bidders should list any subcontractor amounts under the section headed Other, Line 9.

6. If the total price for any subcontractor exceeds 10 percent of the price shown on line 10 for schedules C-1 through C-5 and schedules E-1 through E-5 attach a supplemental C or E schedule for the applicable years in the same format that details and equals the subcontractor price shown on schedules C-1 through C-5 and E-1 through E-5.

7. All C and E schedules shall be used, if applicable, if the contract is ever amended for the services provided by the contractor or subcontractor, in accordance with Attachment L.

5.3.4.6 Pricing Schedule F – Staffing Rate Card

Pricing Schedule F shall contain single fully loaded hourly rates that shall be used for prioritized system enhancement change control work. These rates will be used for contractor enhancement work that exceeds the base contract allowance (25,000 hours annually) and for other major enhancements under contract amendments as described in Attachment D.

The Bidder shall enter the hourly rates in columns C-G corresponding to appropriate contract period. The rates shall not exceed the escalation factor used to calculate the average hourly rates for pricing schedules C1-C5 and E1-E5.

5.3.5 Software and Hardware Information (Tab 3)

Tab 3 shall be labeled “Software and Hardware Information.” The Bidder must include the following:

1. The Bidder will provide a full network conceptual architectural diagram as described in Attachment E, Section E.1.12 to be submitted as part of the proposal. During contract negotiations, the selected vendor will work with Information Resource Management (IRM) to include a preliminary draft diagram for each proposed environment. The architecture diagrams will be finalized during the design task after submission and approval by the ARB. The draft diagrams will be included in the final Contract.

2. The Bidder will provide separately a preliminary list of software and hardware that will be required to meet Delaware requirements for the new DMES.

    a. For the listing of Hardware, the Bidder will provide the following information in a table format:

        1) Identify the specific hardware.

        2) Provide a brief description of its intended use.

        3) Identify its components and subcomponents if applicable.

    b. For the listing of Software, the Bidder must provide the following information in a table format:

        1) Identify the software application.

        2) Identify whether the software is proprietary or COTS software, as defined by State Medicaid Manual (SMM), Part 11.

        3) Provide the licensing structure (terms and conditions) if available.

All licenses must be in the name of the State and at a minimum must provide for separate development, test, and production environments.

5.4 Corporate Confidential Information Disk 3

The Bidder shall describe its corporate stability and resources that will allow it to complete a project of this scale and meet all of the requirements contained in this RFP. The Bidder’s demonstration of its financial solvency and sufficiency of corporate resources is dependent upon whether the Bidder's organization is publicly held or not:

- If the Bidder is a publicly held corporation, enclose a copy of the corporation's most recent 3 years of audited financial reports and financial statements, a recent Dun and Bradstreet credit report, and the name, address, and telephone number of a responsible representative of the Bidder's principle financial or banking organization; include this

information with copy of the Technical Proposal and reference the enclosure as the response to this subsection; or

- If the Bidder is not a publicly held corporation, the Bidder may either comply with the preceding paragraph or describe the bidding organization, including size, longevity, client base, areas of specialization and expertise, a recent Dun and Bradstreet credit report, and any other pertinent information in such a manner that the proposal evaluator may reasonably formulate a determination about the stability and financial strength of the bidding organization; also to be provided is a bank reference and a credit rating (with the name of the rating service); and
- Disclosure of any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the bidding organization; or warrant that no such condition is known to exist.

This level of detail must also be provided for any subcontractors that are proposed to complete at least 10 percent of the proposed statement of work.

The Bidder must submit the following to be used in the evaluation of financial viability:

1. Audited financial statements (annual reports) for the last 3 years. If the Bidder cannot share complete financial statements for at least the most recent 3 years, the Bidder must include written explanation for not including these items.

2. A minimum of three financial references (e.g., letters from creditors, letters from banking institutions, Dunn and Bradstreet supplier reports).

3. A description of other contracts or projects currently undertaken by the Bidder.

4. A summary of any pending litigation, administrative or regulatory proceedings or other similar matters that could affect the ability of the Bidder to perform the required services.

5. A disclosure of any contracts during the preceding five (5) year period, in which the Bidder or subcontractor identified in the bid Proposal, has defaulted, delivered and executed corrective actions plans, or was assessed actual or liquidated damages. List all such contracts and provide a brief description of the incident, the name of the contract, a contact person, and telephone number for the other party to the contract.

6. A disclosure of any contracts during the preceding five (5) year period, in which the Bidder or any subcontractor identified in the bid proposal has terminated a contract prior to its stated term or has had a contract terminated by the other party prior to its stated term. List all such contracts and provide a brief description of the incident, the name of the contract, a contact person, and telephone number for the other party to the contract.

6 EVALUATION OF BID PROPOSALS

6.1 Introduction

The State will conduct a comprehensive, fair, and impartial evaluation of proposals received in response to this procurement effort. The State reserves the right to reject any and all proposals.

The evaluation will be conducted in three tiers:

- Tier 1 – The Mandatory Submission Requirements will be evaluated.
- Tier 2 – The Technical and Cost Proposals will be evaluated.
- Tier 3 – The Executive Selection Committee will review Evaluation Team findings.

DHSS will conduct a three-tiered review process for this project. In the first tier, each Technical Proposal will be evaluated to determine if it meets the Mandatory Submission Requirements described in Attachment P. **Any proposal failing to meet those requirements is subject to immediate disqualification without further review.** All proposals meeting the mandatory submission requirements will be provided to the DHSS Evaluation Team.

In the second tier, the Evaluation Team will perform Technical and Cost Proposal Reviews. The Technical Proposals will be opened on the date and time listed in Section 2.1. The technical evaluators will evaluate the corporate background and experience, project management, approach to start-up and operations, understanding of the procurement project, and other specified items for each proposal that meets the mandatory requirements. The specific evaluation criteria are detailed in Section 6.5.

Bidders that meet the mandatory requirements and achieve an adequate (see Section 6.5) technical score will have their Cost Proposals opened on the date and time listed in Section 2.1. The Cost Proposal evaluation process begins with a review of the mandatory items of the Cost Proposals. The Cost Proposal evaluators will evaluate the price for each component and the total proposal price for each Cost Proposal.

Evaluators will conduct a strictly controlled evaluation of the Technical Proposals submitted in response to this RFP. The evaluators will use prescribed evaluation criteria to score each proposal on its own merit regarding the Bidder's response to the requirements and adherence to the instructions in this RFP. The evaluators will not discuss the contents of the proposals with each other or anyone else during the evaluation process. The evaluators will be closely proctored to ensure that they follow the established rules of the evaluation.

Bidders may be required to demonstrate their proposed solutions and qualifications of their key staff during Oral Presentations. The Oral Presentations (demonstrations by key staff) will be used in the Evaluation Team's final deliberations.

6.2 Evaluation Team

The State will establish an evaluation team composed of selected DHSS staff and other State staff or technical experts, as deemed appropriate.

6.3 Evaluation of Mandatory Requirements

Each proposal will be reviewed for responsiveness to the mandatory requirements set forth in the RFP. This will be a yes/no evaluation and proposals that fail to satisfy all of the criteria of this category may not be considered further for the award of a Contract.

The purpose of this task is to determine if the Technical Proposal is sufficiently responsive to permit a complete evaluation. Mandatory requirements for the Technical Proposal are presented in a checklist in Attachment P.

No points will be awarded for passing the mandatory requirements.

Failure to adequately meet any one (1) mandatory requirement may cause the entire proposal to be deemed non-responsive and be rejected from further consideration. However, the State reserves the right to waive minor irregularities and minor instances of non-compliance.

6.4 Evaluation of Bidder Financial Viability

Bidder proposals are also subject to a review of the Contractor's financial viability. DHSS may designate a third party or contractor to conduct a review of financial statements and financial references that are provided in the Company Financial Information section of the Bidder's proposal.

6.5 Evaluation and Scoring of Technical Proposals

Scoring of Technical Proposals shall be done using pre-established criteria and predefined scoring values. Evaluators will use the evaluation criteria in each area to independently score the Technical Proposals. The individual raw scores from each evaluator for each section of the proposal will be totaled and divided by the number of evaluators to attain a total average score for each section. All sections will then be added to attain a total Technical Proposal score. The final technical score for each proposal will then be calculated using the following methodology:

A maximum of one thousand seven hundred thirty five (1,735) points will be assigned to the highest passing Technical Proposal.

Points for other proposals will be assigned using the formula:

(N/X) x 1,735 = Z

Where:

X = highest points awarded to a proposal

N = actual points awarded to the Bidder's proposal

Z = final technical score for Bidder

6.5.1 Independent Evaluation of Technical Proposals

Only those proposals passing the mandatory requirements will be considered for Tier 2.

The technical proposals will be evaluated independently by the designated evaluation team members during this task and comprise the substantive portion of the total proposal scoring. The State will evaluate the responses based on the instructions provided in this RFP, including the instructions to the Bidder regarding the detail of their responses. In Section 5.2.8, Bidders have been instructed to not simply provide statements that the requirements of the RFP will be met, but to respond concisely but fully with their approach and how they will comply with the requirements in each item listed in this RFP.

The criteria used to evaluate the Technical Proposals are described in the subsections below. Any Technical Proposal in which there are significant inconsistencies or inaccuracies may be rejected by the State. The State reserves the right to reject any and all proposals. The State may conduct reference checks of personnel bid and check corporate references, whether included in the proposal or not. As stated in Section 6, the State may use an independent technical expert in reviewing the proposals.

6.5.2 Evaluation Points for Technical Proposals

The Technical Proposal evaluation will be conducted using the process described in the sub-sections below. The total scoring for the Technical Proposal is as follows:

Technical Proposal Evaluation Points

Category	Maximum Assigned Points
Understanding of DMES Solution and Teaming Approach	150
Corporate Background and Experience	100
Project Management Oversight and Planning	150
Design, Development, and Testing Tasks	300
Implementation and Training	100
Fiscal Agent Operations	200
System Operation and Maintenance Support	200
Certification	45
Staffing	140
Turnover	50
Enterprise Architecture	300
Total	1,735

Evaluation criteria have been developed to cover each of these areas. The following paragraphs describe generally the factors covered by the detailed criteria.

6.5.3 Description of Evaluation Criteria

6.5.3.1 Understanding of the Teaming Approach of the Delaware Medicaid Enterprise System Solution

This part of the evaluation assesses the Bidder's overall understanding of the State's goals and objectives of this procurement. The evaluation criteria for the understanding of the DMES Procurement Project are:

1. The extent to which the Bidder demonstrates its understanding of the project teaming approach. The Bidder must also explain in a descriptive narrative format the importance of the Integrator role in establishing data and interoperability standards for the Core DMES to facilitate future incremental, cost-effective system component and modular enhancement.

2. The extent to which the Bidder demonstrates its understanding of the risks inherent in a project of this size and potential mitigation strategies based on industry best practices and lessons learned.

3. The extent to which the Bidder describes its understanding of the impacts of the new DMES on providers and stakeholders.

RFP Reference: Section 4.1 through Section 4.6 and Section 5.2.5.

6.5.3.2 Corporate Background and Experience

This part of the evaluation assesses the experience, performance, corporate resources, and corporate qualifications of the Bidder and any subcontractors. References will be verified and findings will be incorporated into the evaluation of the corporation. Reference checking may not be limited to those references supplied by the Bidder. The evaluation criteria for Corporate Background and Experience includes all Medicaid contracts (including subcontracts) within the last 5 years and in a format as described in Section 5.2.6.2 to include:

1. Background information for the corporation and subcontractors:

    a. Other government projects of a similar scale.

    b. Company size and resources.

    c. Name of Contractor or subcontractor.

    d. Date of establishment.

    e. Type of ownership (e.g., public/private company, partnership, subsidiary).

    f. The Federal Employer's Identification Number (FEIN) and Delaware Corporate Charter Number.

    g. The primary line of business.

    h. The total number of employees.

    i. The number of personnel engaged in computer systems development and operations.

j. The number of personnel engaged in Medicaid systems development and operation.

2. Corporate experience including all Medicaid contracts (including subcontracts) within the last 5 years and in a format as described in Section 5.2.6 to include:

   a. Other government projects of similar scale.

   b. Experience with large-scale data processing system development.

   c. Experience with the operation of a large-scale data processing system.

   d. Experience with MMIS and clear indications of which projects demonstrate experience with system design and development, implementation, operation, modification, certification, or turnover.

   e. Experience with multiple benefit plan administration.

   f. Experience with Web portal development and operations.

   g. Experience with encounter data.

   h. Experience working directly with managed care providers, e.g., HMOs.

   i. Experience as a fiscal agent or fiscal intermediary.

   j. Experience with other health care systems.

3. Corporate references are provided for the Contractor and subcontractors, as described in Section 5.2.6.

RFP Reference: Section 5.2.6.

6.5.3.3 Project Management Oversight and Planning

This section presents the evaluation criteria that the Bidder response will be measured against for all Project Management tasks and deliverables. The evaluation criteria are as follows:

1. The extent to which the Bidder demonstrates its understanding of the processes required to ensure that the various elements of the project, including documenting system development processes are properly coordinated, managed, and controlled.

2. The extent to which all project activities have been integrated into a comprehensive project plan and the Bidder has demonstrated how its project management approach contributes to successful projects that achieve technical and cost objectives.

3. The extent to which the Bidder provides a Project Plan with the proposal that meets the requirements in the SOW (Attachment B, Section B.1.12), and all deliverables in Attachment E, Section E.1.1.

4. The extent to which the Bidder is able to meet: the facilities and equipment requirements; the provisioning of facility services; and required operational functions to be maintained at the local facility.

RFP References: Section 5.2.7 and Section 5.2.14, Attachment B, Section B.1.11 and Section B.1.12, and Attachment E, Section E.1.1.

6.5.3.4 Technical Approach to Design, Development, and Testing

This section presents the evaluation criteria that will measure the Bidder's responses to technical approach to design and construction of the new DMES, the technical architecture, systems integration, and to the quality control and testing approach as described in Section 5.2.9 and Attachment B, Section B.1.12 through Section B.1.19. The evaluation criteria are as follows:

1. The extent to which the Bidder includes a Project Plan that addresses project schedule and work breakdown structure and quality control.

2. The extent to which the Bidder successfully describes a Software Development Methodology and associated tools used for producing project deliverables that have proven successful on projects of similar size and complexity as specified in Attachment E.

3. The extent to which the Bidder's methodology addresses all components of the DMES, including Web applications.

4. The extent to which the proposed methodology demonstrates an understanding of the complexities involved in developing a system comparable to the DMES.

5. The extent to which the proposed tool set is likely to provide control over the development process. Preference will be given to Bidders who have achieved Level 2 or above Capability Maturity Model Integration (CMMI).

6. The extent to which the controls the Bidder uses to create and manage requirement changes for the new DMES and enhancements ensure that all changes are fully evaluated, all required approvals are obtained, and changes are completed within the required timeframes.

7. The extent to which the Bidder demonstrates that its use of the proposed system development methodologies and tool sets support the detailed Requirements Analysis, design and construction, and that the use of the Project Repository Intranet ensures that Project artifacts are current.

8. The extent to which the Bidder demonstrates an understanding of the importance of the design task activities and the development and review of design deliverables.

9. The extent to which the Bidder demonstrates its knowledge and experience in using development tools in the design task.

10. The extent to which the Bidder's approach to measuring system construction activities and the involvement of DHSS, Bidder, and quality assurance staff will ensure product quality and adherence to design requirements.

11. The extent to which the Bidder's configuration management and control processes with multiple regions for development and testing, user acceptance testing, conversion and training will ensure that all activities utilize the correct files and software.

12. The extent to which the Bidder demonstrates that its use of the Project Repository ensures that Project artifacts are current.

13. The extent to which the Bidder's approach to testing will ensure that all required functions will meet RFP requirements prior to implementation.

14. The extent to which the Bidder's test case tracking and issue resolution mechanisms will ensure that all identified problems can be tracked and retested to ensure that results are in compliance with the requirements, and that all testing can be completed within the required timeframes.

16. The extent to which the Bidder can demonstrate that it can ensure complete identification of the other relevant DHSS systems and interfaces and how the new DMES will be designed and maintained to ensure compatibility with the system interfaces.

17. The extent to which the Bidder demonstrates its preparedness to protect the system against hardware and software failures, human error, natural disasters, and other emergencies, which could interrupt services.

18. The extent to which the Bidder is able to demonstrates a successful recovery of business functions, business units, business processes, human resources, and the technology infrastructure in the event of a disaster.

19. The extent to which the Bidder demonstrates its understanding of the system documentation requirements.

20. The extent to which the Bidder demonstrates its understanding of Operational Readiness Testing and preparedness.

21. The extent to which the Bidder is able to demonstrate the proposed DMES meets all HIPAA requirements including ICD-10, and will remain compliant as HIPAA Rules are enhanced.

RFP References: Section 5.2.9, Attachment B, Section B.1.12 through Section B.1.19*, and Attachment E, Section E.1.1 through Section E.1.27.*

6.5.3.5 Technical Approach to Implementation and Training

This part of the evaluation assesses the Bidder's approach to the Implementation and Training Tasks, including production environment and conversion preparedness. The evaluation criteria for Technical Approach to Implementation and Training are:

1. The extent to which the Bidder includes a Project Plan that addresses project schedule and work breakdown structure describing the implementation, conversion, and training tasks. The proposed Project Plan shall meet the requirements in Attachment E, Section E.1.1.

2. The extent to which the Bidder describes its technical approach to implementation of the new DMES, as defined in Section 5.2.10.

3. The extent to which the Bidder demonstrates its knowledge of developing a plan that will ensure that the implementation and conversion tasks will result in accurate migration of system data to the new DMES.

4. The extent to which the Bidder provides a proposed Data Conversion Strategy with the proposal that meets the standard established in Attachment E, Section E.1.22.

5. The extent to which the Bidder provides an acceptable implementation plan for the POS PBM modules or system components.

6. The extent of the Bidder's experience with training under other MMIS contracts.

7. The Bidder's approach to developing the training plan.

8. The extent to which the Bidder's training approach and the differentiation between user, technical, and provider training requirements demonstrates an understanding of the DMES and consideration for stakeholders, the DHSS organization, and the provider community.

9. The extent to which the Bidder demonstrates an understanding of the responsibilities of the DHSS and Bidder training staff.

10. The extent to which the Bidder has had experience in integrating system training with business process training.

11. The extent to which the Bidder demonstrates experience in developing user manuals and desktop procedures for a variety of organizations and applications in multiple media.

12. The extent to which the Bidder is able to demonstrate and describe its understanding and approach to preparing the Implementation Certification Letter including the quality assurance process to assure all of the requirements addressed in the letter have been fulfilled.

RFP References: Section 5.2.10, RFP Attachment B, Section B.1.18 and Section B.1.19, and Attachment E, Section E.1.10, Section E.1.28 through Section E.1.32, and Section E.1.34.

6.5.3.6 Technical Approach to Fiscal Agent Operations

This part of the evaluation assesses the Bidder's overall approach to FA Operations including the POS PBM. The evaluation criteria for FA Operations are:

1. The extent to which the Bidder describes its proposed solution and demonstrates its ability to meet technical requirements from the CMS MECT checklists in Attachment C and the operational requirements from the business areas.

2. The extent to which the Bidder describes its understanding as to the importance of establishing a Quality Management Plan (QMP) for managing and executing operations and as described in Attachment E, Section E.1.35.

3. The extent to which the Bidder addresses its approach to the three (3) key areas of the QMP, quality planning, quality assurance, and quality control, and includes discussion regarding tools and techniques, quality metrics, measures and established standards, and meeting stakeholder expectations.

4. The extent to which the Bidder addresses its plans for establishing continuous process improvement initiatives that become part of the FA organizational and operating culture and facilitates innovation and operational efficiencies.

5. The extent to which the Bidder demonstrates its understanding of the approach to producing a staffing capabilities report on a semi-annual basis which includes discussion relating to the recruiting and training of new staff, retention and cross-training of existing staff, and opportunities to further align and maximize the efficiency of staffing positions.

6. The extent to which the Bidder explains its approach and understanding of the weekly and annual status reporting requirements.

RFP References: 5.2.11, Attachment B, Section B.1.20 and Section B.1.23, Attachment E, Sections E.1.35 through Section E.1.38, and Attachment C.

6.5.4 Technical Approach to System Operation and Maintenance Support

This part assesses the Bidder's overall approach and understanding of the IT Operations and Maintenance support tasks. The evaluation criteria are:

1. The extent to which the Bidder demonstrates its understanding of the transition activities that will take place as it relates to the moving the overall organization structure from implementation to the support task.

2. The extent to which the Bidder demonstrates its plan for the ongoing management of SOA integration services to include: operation and maintenance of the SOA framework and ESB, management and administration of all open APIs, participation on the SOA Governance Committee and the scheduling of meetings as specified by the State, interface definition and inventory, and support team staff identification.

3. The extent to which the Bidder demonstrates its understanding regarding how the POS PBM systems will be maintained over the life of the Contract.

4. The extent to which the Bidder demonstrates its understanding regarding how the Core DMES modules will be maintained over the life of the Contract.

5. The extent to which the Bidder addresses help desk program and staffing, including details on problem identification, escalation, and resolution.

6. The extent to which the Bidder demonstrates its understanding and approach to staffing and planning for system modifications, changes and enhancements, including the project management approach and the change management process.

7. The extent to which the Bidder identifies any items that call for the support of the DMES to be different in any way other than that for the POS PBM.

8. The extent to which the Bidder demonstrates its understanding and approach to producing a staffing capabilities report semi-annually discussing the recruiting and training of new staff, retention and cross-training of existing staff, and opportunities to further align and maximize the efficiency of staffing positions.

9. The extent to which the Bidder demonstrates its approach and understanding of the weekly and annual status reporting requirements.

Preference will be given for team staff that continues from DDI to O&M.

RFP References: Section 5.2.12, Attachment B, Section B.1.22, and Attachment E, Section E.1.37, Section E.1.38, and Section E.1.41 through Section E.1.44, and Attachment D.

6.5.4.1 Technical Approach to Certification

The evaluators will assess the Bidder's approach to Certification. The evaluation criteria for the DMES Certification Task are:

1. The extent to which the Bidder includes a Project Plan with a work breakdown structure and project schedule that addresses the Certification Task.
2. The extent to which the Bidder understands the process and timeline for obtaining federal certification of the DMES.
3. The extent to which the Bidder's approach ensures that the DMES meets all federal requirements for certification.
4. The extent to which the Bidder exhibits a clear understanding of its role in the certification, documentation, and artifact gathering process including:
    a. Participation in certification planning.
    b. Preparation and assembly of review materials.
    c. Assisting the State in developing certification presentation materials.
    d. Provision of all system outputs needed to demonstrate full functionality from the start of operations.
    e. Participation in the federal onsite certification review as necessary.
    f. Assistance with answering federal review team questions.
    g. Participation in the correction of any deficiencies identified during the review within a time period agreed upon between the State and the federal review team.
    h. The provision of any additional materials needed to resolve post-review corrective actions.

RFP References: Section 5.2.12, Attachment B, Section B.1.21, and Attachment E, Section E.1.1, Section E.1.39, and Section E.1.40.

6.5.4.2 Management Approach to Contractor Staffing

This part of the evaluation assesses the Bidder's approach to Staffing. Using the criteria submitted in Section 5.2.14, the State seeks to gain a clear understanding of the total staffing solution proposed by the Bidder. The Bidder must demonstrate its ability to recruit and retain qualified, highly skilled staff that is versatile and consistently meets deliverable expectations. In particular, the Bidder's management, supervisory, or other key personnel assigned to the Contract will be evaluated for their experience and qualification with emphasis on documented experience in successfully completing work on contracts of similar size and scope required by this RFP. The evaluation criteria are as follows:

1. The extent to which the Bidder manages its staffing resources through its organization and management structure and its policies related to work quality and cost to support its ability to complete the requirements of the RFP.
2. The extent to which the loading of staffing levels by resource type and the total effort as compared to the project schedule in the Project Plan supports the Bidder's ability to complete the tasks identified in the RFP.
3. The extent to which the Bidder demonstrates its ability to build successful collaborative relationships with the client and subcontractors while demonstrating its commitment to each task of the project and throughout the DMES project life cycle.
4. The extent to which the proposed project team demonstrates knowledge, training, and experience in quality management strategies and methodologies. Demonstration of accomplishments within their respective proposed roles and responsibilities, and as expressed through each of their references, also demonstrates the Bidder's ability to complete the project required by this RFP. Preference will be given to a team that has previously worked together. Named Staff include those developing and supporting the DMES and PBM.
5. The extent to which the Bidder is able to demonstrate commitment by mobilizing the appropriate number and quality of staff, and as depicted in the Contract organizational chart.

RFP Reference: Section 5.2.14.

6.5.4.3 Technical Approach to Turnover Task

This part of the evaluation assesses the Bidder's approach to the Approach to Turnover Task. The evaluation criteria for the Approach to Turnover Task are:

1. Project management approach for this task, as described in Sections 5.2.8 and Section 5.2.15.
2. Work plan and a schedule for this task, as described in Section 5.2.8 and Section 5.2.15.
3. Technical approach for this task, as described in Section 5.2.8 and Section 5.2.15.
4. Approach to general planning with DMMA.
5. Approach to general planning with the successor.
6. Approach to the development of the Turnover Plan.
7. Approach to the development of the DMES requirements statement.
8. Approach to providing turnover services, which includes cooperation with the successor and the turnover of archived materials.
9. Approach to contract closeout services, including:
    a. Financial reconciliation.
    b. Written assessment of contract performance.
    c. Resolution of turnover issues.

10. Approach to fulfilling responsibilities, including:

    a. Contractor facilities.

    b. Staffing and resources.

    c. Turnover of DMES.

    d. Turnover of system documentation.

    e. Turnover training.

    f. Facilitation of successor acceptance testing.

    g. Final turnover of up-to-date system, data, paper files, and documentation.

RFP References: Section 5.2.8 and Section 5.2.15, Attachment B, Section B.1.24, Attachment E, Section E.1.45 and Section E.1.46.

6.5.4.4 Technical Approach to Enterprise Architecture

This part of the evaluation assesses the Bidder's approach to understanding the Enterprise Architecture including each of the Functional Requirements specified in Attachment C that apply to all modules, system components, and operational aspects of the Solution. The evaluation criteria for the Approach to Enterprise Architecture are:

1. Extent to which the Bidder demonstrates its understanding with regard to each of the Seven Conditions and Standards in the CMS "Enhanced Funding Requirements: Seven Conditions and Standards" Medicaid Information Technology (IT) Supplement (MITS-11-01-v1.0).

2. The extent to which the Bidder demonstrates an understanding of the technological environments and requirements for the DMES Project.

3. The extent to which the Bidder understands the requirements for providing browser-based access to the new DMES for DHSS staff and partners, and hardware, software, and capacity requirements to establish a technical environment necessary to support the DMES.

4. The extent to which the Bidder's final solution is based upon modern architectural design principles and the extent of modification needed to modernize the architecture beyond the Base System.

5. The Bidder's understanding, ability, and commitment to keeping system technology current over time.

6. The extent to which the Bidder demonstrates its understanding and approach to building and deploying an SOA and using COTS and Web-based products functioning as architectural components. Products may include, but are not limited to rules engines, workflow engine and documentation management system, EDI, and Web portal.

7. The extent to which the Bidder demonstrates its understanding and approach to general MITA requirements, including implementing and operating a solution where the majority

of its business processes achieve MML 3 or greater, such as SOA using an ESB infrastructure.

8. The extent to which the Bidder demonstrates its understanding and approach as it relates to the State's s IT Standards.

RFP References: Section 5.2.16, Attachment B, Section B.1.14 through Section B.1.21, Attachment C, Attachment E, Section E.1.11 and Section E.1.12.

6.5.5 Oral Presentations/Site Visits

Tier 2 of the evaluation process is comprised of two Bidder events:

1. Bidder Oral Presentations.
2. State pre-arranged visits to Bidder sites.

The State will require oral presentations by Bidders successfully completing mandatory requirements and meeting the technical score threshold. The oral presentations will be arranged with Bidders individually during the State's evaluation. The State shall expect proposed Named Staff to play a key role in Oral Presentations.

In addition to the Oral Presentations, the State may elect to conduct a site visit. The site visit will be at Bidder locations at which MMIS or large medical claim payment systems are operational or at which the Bidder provides FA services. The State will select the location of the site visit from a list of suggested sites supplied by the Bidder. It shall be the State's preference to visit sites at which an operational MMIS has been developed and installed by the Bidder at a site that is comparable in size and complexity to the DMMA program. At the site visits, each Bidder shall be expected to respond to specific questions and to have appropriate personnel (including the proposed project manager) available for discussions. Relevant systems documentation, procedure manuals, edit tables, and operational processes shall be available for review by State staff. The State staff that conducts the site visits will record its observations of the Bidder's operations at the site selected, which will be shared with all evaluators.

The observations by the evaluators during Oral Presentations and site visits will be considered in assigning points to the Technical Proposal.

6.6 Evaluation and Scoring of Cost Proposal

If determined that the responses to requirements in the Bidder's Technical Proposal address 75 percent or more of the total questions scoring adequate or better, the Bidder's Cost Proposals will be opened in accordance with the specification in Section 6.1. The Cost Proposals will be evaluated to ensure that all mandatory requirements have been met. The purpose of this evaluation is to determine if the Cost Proposals are sufficiently responsive to the requirements as stated in Section 5 and if the Cost Proposals' required items are included in Attachment K to permit a complete evaluation. No points will be awarded for passing mandatory requirements.

Each Cost Proposal successfully meeting the mandatory requirements reviewed in Tier 1 will be examined to determine if the Cost Proposal is consistent with the Technical Proposal and its calculations are accurate. All pricing schedules will be examined for consistency and accuracy.

A total of 743 points will be awarded to the lowest price from Pricing Schedule A, Line 5.

Points for other Cost Proposals will be awarded using the formula:

(X/N) x 743 = Z

Where:

X = lowest price proposal

N = proposal price

Z = awarded points

Total score will be based on the costs submitted as part of the cost worksheet. Strong consideration will be given to how well the costs in the Project Cost Forms compare to the level of effort for this proposal along with the accuracy of the submitted figures. The State of Delaware reserves the right to reject, as technically unqualified, proposals that are unrealistically low if, in the judgment of the evaluation team, a lack of sufficient budgeted resources would jeopardize project success.

Total Maximum Cost Score	743

6.7 Proposal Ranking and Award

Final scores for the Technical and Cost Proposals will be added to determine a total score for each proposal. The proposals will then be ranked from first to last, with first being the proposal with the highest total score. The Issuing Officer will then provide the Contracting Officer with the ranking and a report on the evaluation process.

6.8 The Executive Selection Committee Review Process (Tier 3)

In the third tier, the Evaluation Team findings will be presented to the Executive Selection Committee. The Executive Selection Committee will review Evaluation Team findings. A potential Contractor will be recommended to the Secretary of the Department of Health and Social Services. Final selection is at the discretion of the Secretary or her/his designee.

6.9 Federal Approvals

Federal approval of the Contract for services between the selected Contractor and the State is required from CMS. Every effort will be made by DHSS to obtain and expedite federal approval.

Attachments Table of Contents

A ATTACHMENT A: GENERAL INFORMATION A-1

A.1 DHSS Program Overview A-1
A.2 The Division of Medicaid and Medical Assistance A-1
A.3 Fiscal Agent Support Services A-2
A.3.1 Fiscal Agent Services Provided to DMMA A-3
A.3.1.1 Claims Adjudication A-3
A.3.1.2 Claims Control and Entry A-3
A.3.1.3 Client A-3
A.3.1.4 Drug Rebate A-4
A.3.1.5 Drug Utilization Review A-4
A.3.1.6 ePrescribing A-4
A.3.1.7 Electronic Verification System A-4
A.3.1.8 Financial A-5
A.3.1.9 Electronic Health Records (EHR) Incentive Payment Program A-5
A.3.1.10 Management and Administrative Reporting A-6
A.3.1.11 Managed Care A-6
A.3.1.12 Prior Authorization A-7
A.3.1.13 Provider A-7
A.3.1.14 Reference Data Maintenance A-8
A.3.1.15 Surveillance and Utilization Review Subsystem A-8
A.3.1.16 Third-Party Liability A-8
A.3.1.17 DMAP Website A-8
A.3.1.18 Health Benefits Manager A-9
A.3.1.19 McKesson Claim Check® A-9
A.4 Background and Documentation A-9

B ATTACHMENT B: STATEMENT OF WORK B-1

B.1 Statement of Work B-1
B.1.1 Contractor Activities B-2
B.1.2 DHSS General Responsibilities B-2
B.1.3 Contractor General Responsibilities B-2
B.1.4 Project Staffing B-3
B.1.5 Project Deliverables B-4
B.1.6 Role of QA Contractor B-5
B.1.7 Implementation Strategy B-5
B.1.8 Onsite Staffing Requirement B-5
B.1.9 Offsite Project Work B-6
B.1.10 Offshore Project Work B-7
B.1.11 Facilities and Equipment B-7
B.1.11.1 DDI Phase Requirements B-8
B.1.12 Task 1 – Project Management B-9
B.1.12.1 Objectives B-9
B.1.12.2 DHSS Project Management Responsibilities B-9
B.1.12.3 Contractor Project Management Responsibilities B-10
B.1.12.4 Personnel Requirements B-10
B.1.12.5 Milestones B-11
B.1.12.6 Deliverables B-11
B.1.13 Task 2 – Detailed Requirements Analysis B-12
B.1.13.1 Objectives B-12
B.1.13.2 DHSS Detailed Requirements Analysis Responsibilities B-12
B.1.13.3 Contractor Detailed Requirements Analysis Responsibilities B-13
B.1.13.4 Personnel Requirements B-14

B.1.13.5 Milestones B-14
B.1.13.6 Deliverables B-15
B.1.14 Task 3 – Design B-15
B.1.14.1 Objectives B-15
B.1.14.2 DHSS Design Responsibilities B-16
B.1.14.3 Contractor Design Responsibilities B-17
B.1.14.4 Milestones B-17
B.1.14.5 Deliverables B-17
B.1.15 Task 4 – Development B-18
B.1.15.1 Objectives B-18
B.1.15.2 DHSS Development Responsibilities B-18
B.1.15.3 Contractor Development Responsibilities B-19
B.1.15.4 Milestones B-19
B.1.15.5 Deliverables B-20
B.1.16 Task 5 – Data Conversion B-20
B.1.16.1 Objectives B-21
B.1.16.2 DHSS Conversion Responsibilities B-21
B.1.16.3 Contractor Data Conversion Responsibilities B-21
B.1.16.4 Milestones B-22
B.1.16.5 Deliverables B-22
B.1.17 Task 6 – Acceptance Testing B-22
B.1.17.1 Objectives B-22
B.1.17.2 Letter Certifying that the DMES Is Ready for UAT B-23
B.1.17.3 DHSS Acceptance Test Responsibilities B-23
B.1.17.4 Contractor Acceptance Test Responsibilities B-23
B.1.17.5 Milestones B-24
B.1.17.6 Deliverables B-24
B.1.18 Task 7 – Training B-25
B.1.18.1 Objectives B-25
B.1.18.2 DHSS Training Responsibilities B-26
B.1.18.3 Contractor Training Responsibilities B-27
B.1.18.4 Milestones B-27
B.1.18.5 Deliverables B-27
B.1.19 Task 8 – Implementation B-28
B.1.19.1 Objectives B-28
B.1.19.2 DHSS Implementation Responsibilities B-28
B.1.19.3 Contractor Implementation Responsibilities B-29
B.1.19.4 Milestones B-29
B.1.19.5 Deliverables B-30
B.1.20 Task 9 – Operations – Fiscal Agent Services B-30
B.1.20.1 Objectives B-31
B.1.20.2 DHSS Responsibilities B-31
B.1.20.3 Contractor Responsibilities B-32
B.1.20.4 Personnel Requirements B-33
B.1.20.5 Milestones B-33
B.1.20.6 Deliverables B-34
B.1.21 Task 10 – Certification B-34
B.1.21.1 Objectives B-34
B.1.21.2 DHSS Certification Responsibilities B-34
B.1.21.3 Contractor Certification Responsibilities B-35
B.1.21.4 Milestones B-35
B.1.21.5 Deliverables B-36
B.1.22 Task 11 – Systems Operations and Maintenance Support B-36
B.1.22.1 Objectives B-37
B.1.22.2 DHSS Responsibilities B-37
B.1.22.3 Contractor Responsibilities B-37

B.1.22.4 Personnel Requirements....B-39
B.1.22.5 Milestones....B-40
B.1.22.6 Deliverables....B-40
B.1.23 Task 12 – Operations - Pharmacy Benefit Management Services....B-41
B.1.23.1 Objectives....B-41
B.1.23.2 DHSS Responsibilities....B-41
B.1.23.3 Contractor Responsibilities....B-42
B.1.23.4 Personnel Requirements....B-42
B.1.23.5 Milestones....B-43
B.1.23.6 Deliverables....B-43
B.1.24 Task 13 – Turnover....B-43
B.1.24.1 Objectives....B-44
B.1.24.2 DHSS Responsibilities....B-44
B.1.24.3 Contractor Responsibilities....B-44
B.1.24.4 Milestones....B-45
B.1.24.5 Deliverables....B-45

C ATTACHMENT C: DMES FUNCTIONAL REQUIREMENTS....C-1

C.1 Delaware's DMES Functional Requirements....C-1
C.2 System Compliance....C-1
C.2.1 CMS Certification....C-1
C.2.2 Compliance with Federal Standards....C-1
C.2.3 Requirement to Comply with HIPAA Regulations and Standards....C-2
C.2.4 Requirement to Comply with State Policies and Standards....C-5
C.2.5 CMS Enhanced Funding Requirements....C-6
C.3 General System Requirements....C-6
C.3.1 System Design Documentation....C-6
C.3.2 Database Design....C-7
C.3.3 Data Quality Control....C-7
C.3.4 General System Reporting Capabilities....C-8
C.3.5 Architecture Requirements....C-10
C.3.6 Delaware MITA Objectives....C-12
C.3.7 Service Oriented Architecture....C-14
C.3.8 Software License and Maintenance....C-16
C.3.9 Software Escrow....C-16
C.3.10 Change Control....C-17
C.3.11 Records Retention....C-18
C.3.12 User Acceptance Testing....C-19
C.3.13 Degree of Customization....C-20
C.4 General Business Requirements....C-20
C.4.1 Deliverable Standards....C-20
C.4.2 Contract Accounting Requirements....C-21
C.4.3 Payment for Pass-through Items....C-22
C.4.4 Auditing Requirements....C-22
C.5 Business Area Functional Requirements....C-23
C.5.1 Core Functions....C-23
C.5.1.1 Client Management....C-24
C.5.1.1.1 Contractor Business Responsibilities....C-25
C.5.1.1.2 Contractor Technical Requirements....C-29
C.5.1.2 Provider Management....C-41
C.5.1.2.1 Contractor Business Responsibilities....C-41
C.5.1.2.2 Contractor Technical Requirements....C-44
C.5.1.3 Reference Data Maintenance....C-51
C.5.1.3.1 Contractor Business Responsibilities....C-51

C.5.1.3.2 Contractor Technical Requirements C-52
C.5.1.4 Claims Receipt C-55
C.5.1.4.1 Contractor Business Responsibilities C-55
C.5.1.4.2 Contractor Technical Requirements C-56
C.5.1.5 Claims Processing C-59
C.5.1.5.1 Contractor Business Responsibilities C-59
C.5.1.5.2 Contractor Technical Requirements C-61
C.5.1.6 Prior Authorization (PA) Business Area C-71
C.5.1.6.1 Contractor Business Responsibilities C-71
C.5.1.6.2 Contractor Technical Requirements C-71
C.5.1.7 Financial Management C-73
C.5.1.7.1 Contractor Business Responsibilities C-73
C.5.1.7.2 Contractor Technical Requirements C-77
C.5.1.8 Electronic Verification System C-81
C.5.1.8.1 Contractor Business Responsibilities C-82
C.5.1.9 Mail Room Requirements C-84
C.5.1.9.1 Contractor Business Responsibilities C-84
C.5.1.9.2 Contractor Technical Requirements C-85
C.5.2 Pharmacy Benefits Management (PBM) C-86
C.5.2.1 Pharmacy Point of Service (POS) Business Requirements C-86
C.5.2.2 Pharmacy POS General Technical Requirements C-88
C.5.2.3 Pharmacy ePrescribing Requirements C-90
C.5.2.4 Pharmacy POS Claims Processing Technical Requirements C-91
C.5.2.5 Pharmacy POS Prior Authorization Requirements C-92
C.5.2.5.1 Contractor Business Responsibilities C-93
C.5.2.5.2 Contractor Technical Requirements C-93
C.5.2.6 Pharmacy POS Claim Audit Technical Requirements C-94
C.5.2.7 Pharmacy POS Third Party Liability Technical Requirements C-95
C.5.2.8 Pharmacy Drug Rebate Business Area C-96
C.5.2.8.1 Contactor Business Responsibilities C-96
C.5.2.8.2 Contractor Technical Requirements C-98
C.5.2.9 Drug Utilization Review, Prospective and Retrospective Drug Utilization Review (DUR) Business Area C-99
C.5.3 Supporting Modules and System Components outside the Core C-101
C.5.3.1 Web Services (DMAP Website) C-101
C.5.3.1.1 Contractor Business Responsibilities C-102
C.5.3.1.2 Contractor Technical Requirements C-102
C.5.3.2 Document Imaging, Storage and Retrieval C-107
C.5.3.2.1 Contractor Business Responsibilities C-108
C.5.3.2.2 Contractor Technical Requirements C-108
C.5.3.3 Workflow Management Business Area C-112
C.5.3.3.1 Contractor Business Responsibilities C-113
C.5.3.3.2 Contractor Technical Requirements C-113
C.5.3.4 Rules Engine Business Area C-117
C.5.3.4.1 Contractor Technical Requirements C-117
C.5.3.5 Third Party Liability C-118
C.5.3.5.1 Contractor Business Responsibilities C-119
C.5.3.5.2 Contractor Technical Requirements C-121
C.5.3.6 Program Management C-126
C.5.3.6.1 Program Management Reporting C-127
C.5.3.6.1.1 Contractor Technical Requirements C-127
C.5.3.6.2 Federal Reporting C-131
C.5.3.6.2.1 Contractor Business Responsibilities C-131
C.5.3.6.2.2 Contractor Technical Requirements C-132
C.5.3.7 Managed Care Enrollment C-135
C.5.3.7.1 Contractor Business Responsibilities C-135

C.5.3.7.2 Contractor Technical Requirements C-136
C.5.3.8 Managed Care Organization Interfaces C-137
C.5.3.8.1 Contractor Business Responsibilities C-137
C.5.3.8.2 Contractor Technical Requirements C-138
C.5.3.9 HCBS Waivers C-142
C.5.3.9.1 Contractor Technical Requirements C-142
C.5.3.10 Immunization Registry Interfaced C-144
C.5.3.10.1 Contractor Business Responsibilities C-144
C.5.3.10.2 Contractor Technical Requirements C-144
C.5.3.11 Customer Service Business Area C-145
C.5.3.11.1 Contractor Technical Requirements C-145

D ATTACHMENT D: DMES SYSTEMS OPERATIONS AND MAINTENANCE TASKS.... D-1

D.1 Approach to System Maintenance and Enhancements D-1
D.1.1 Overview D-1
D.1.2 Change Control Process D-1
D.2 System Support Services D-2
D.2.1 Maintenance Definition D-2
D.2.2 Examples of Maintenance Functions D-3
D.2.3 Support Services Requirements D-4
D.2.4 Error Prioritization D-4
D.3 Enhancements D-4
D.3.1 Enhancement Definition D-4
D.3.2 Enhancement Tasks D-5
D.3.3 System Enhancement Requirements D-5
D.3.4 Systems Team Staffing/Programming Hours D-6
D.4 Major Enhancements (Projects) D-7
D.4.1 Major Enhancements (Projects) Definition D-7
D.4.2 Project Management D-7
D.5 Coordinating Legacy and DMES updates D-7
D.6 Project Help Desk Staff Requirement D-7

E ATTACHMENT E: DELIVERABLES E-1

E.1 Deliverable Formats E-1
E.1.1 Deliverables 1.1 and 1.2 – Project Plan E-3
E.1.1.1 Project Schedule/Work Breakdown Structure E-4
E.1.1.2 Risk Management Plan E-4
E.1.1.3 Quality Management Plan E-5
E.1.1.4 Staffing Management Plan E-5
E.1.1.5 Communications Management Plan E-7
E.1.1.6 Facilities and Equipment Plan E-7
E.1.2 Deliverable 1.3 – Change Management Plan E-9
E.1.2.1 Organization and Resources E-9
E.1.2.2 Configuration/Change Management Tasks E-9
E.1.2.3 Configuration/Change Management Repositories E-10
E.1.2.4 Configuration Audits and Reviews E-10
E.1.2.5 Other Configuration Management Processes E-10
E.1.3 Deliverable – 1.4 Software Development Methodology E-11
E.1.3.1 Software Development Overview E-11
E.1.3.2 Software Development Methodology E-11
E.1.3.3 Detailed Requirements Analysis and Design Methodology E-11
E.1.4 Deliverable – 1.5 Project Repository E-12
E.1.4.1 Overview, Organization, and Content E-12

E.1.4.2 Repository Management E-12
E.1.4.3 Access to the Project Repository E-12
E.1.4.4 Roles and Responsibilities E-13
E.1.5 Deliverable – 1.6 Project Status Reporting E-13
E.1.5.1 Content E-13
E.1.6 Deliverable – 1.7 Security Policies and Procedures E-14
E.1.6.1 Workforce Security E-14
E.1.6.2 Security Incident Reporting and Response E-14
E.1.6.3 Security Awareness E-14
E.1.7 Deliverable 1.8 & 6.7 – Business Continuity Plan E-14
E.1.7.1 Backup and Recovery Approach E-14
E.1.7.2 Scope E-15
E.1.7.3 Risk Analysis and Action E-15
E.1.7.4 Backup Plan E-15
E.1.7.5 Disaster Recovery Plan E-16
E.1.8 Deliverable 2.1 – Detailed Requirements Specification E-17
E.1.8.1 Requirements Specification Document E-17
E.1.9 Deliverable 3.1, 4.6, 6.8 & 8.6 - Detailed System Design Versions 1, 2, 3 & 4 ..... E-18
E.1.9.1 Detailed System Design Document E-18
E.1.10 Deliverables 3.2, 4.7, & 8.1 – Implementation Plan, Versions 1, 2, & 3 ..... E-19
E.1.10.1 Installation Overview E-19
E.1.10.2 Site-specific Information for Data Center Operations Staff E-19
E.1.10.3 Implementation Issues E-20
E.1.10.4 Transition Planning E-20
E.1.11 Deliverable 3.3 – System Architecture and Design Document E-20
E.1.11.1 General System Architecture E-21
E.1.11.2 Detail System Architecture and Design E-21
E.1.11.3 Interface Design Description and Integration Specification Document E-22
E.1.11.4 Interface Control Document E-24
E.1.11.4.1 Scope E-24
E.1.11.4.2 Interface Requirements E-24
E.1.11.4.3 Interface Design E-25
E.1.12 Deliverable – 3.4 Architectural Review Board Requirements E-25
E.1.12.1 Data Model Standards E-25
E.1.12.2 Network Diagram Standards E-26
E.1.12.3 Process Flow Modeling Standards E-26
E.1.12.4 Software Disclosure List E-26
E.1.12.5 Physical Environment Standard E-26
E.1.13 Deliverable 3.5 – Test Management Plan E-26
E.1.13.1 Approach to Testing E-26
E.1.13.2 Testing Processes E-28
E.1.14 Deliverable – 3.6 Network Upgrade Requirements E-28
E.1.14.1 Network Requirements Specification E-28
E.1.14.2 Desktops E-29
E.1.15 Deliverable – 3.7 Data Conversion Strategy E-29
E.1.15.1 Approach to Developing the Conversion Strategy E-29
E.1.15.2 Scope E-29
E.1.16 Deliverable – 4.1 Development Environment E-30
E.1.16.1 Development Environment E-30
E.1.17 Deliverable – 4.2, 6.6 & 8.3 – Code Library, Versions 1, 2 & 3 ..... E-31
E.1.17.1 Source Code Library Construction E-31
E.1.17.2 Documentation Content E-31
E.1.18 Deliverable – 4.3 & 6.3 – Development Test Results E-32
E.1.18.1 Overview E-32
E.1.18.2 Overall Assessment of the Software Tested E-33
E.1.18.3 Impact of Test Environment E-33

E.1.18.4 Recommended Improvements E-33
E.1.18.5 Detailed Test Results E-33
E.1.18.6 Test Log E-33
E.1.19 Deliverable 4.4 & 8.4 – User Manual, Versions 1 and 2 ..... E-33
E.1.19.1 General Requirements for User Manual E-34
E.1.19.2 User Manual Contents E-34
E.1.20 Deliverable 4.5 & 8.5 – Operating Procedures, Versions 1 & 2 ..... E-35
E.1.20.1 General Requirements for Operating Procedures E-35
E.1.20.2 Contents of Operating Procedures E-35
E.1.21 Deliverable 5.1 - Data Conversion Plan E-36
E.1.21.1 Data Conversion Tasks E-36
E.1.21.2 Resource Requirements E-37
E.1.21.3 Schedule E-38
E.1.22 Deliverable 5.2 – Conversion Test Results E-38
E.1.22.1 Scope E-38
E.1.22.2 Overview of Test Results E-38
E.1.22.3 Detailed Test Results E-38
E.1.22.4 Test Log E-39
E.1.22.5 Notes E-39
E.1.23 Deliverable 6.1 – Test Environment E-39
E.1.23.1 Test Environment E-40
E.1.24 Deliverable 6.2 – Acceptance Test Plan E-40
E.1.24.1 Test Preparations E-40
E.1.24.2 Test Descriptions E-40
E.1.24.3 Defect/Issue Tracking Tools E-41
E.1.24.4 Requirements Traceability E-41
E.1.25 Deliverable 6.3 – Acceptance Test Results E-41
E.1.25.1 Overall Assessment of the Software Tested E-41
E.1.25.2 Impact of Test Environment E-42
E.1.25.3 Recommended Improvements E-42
E.1.25.4 Detailed Test Results E-42
E.1.25.5 Test Log E-42
E.1.26 Deliverable 6.4 – Operational Readiness Testing (ORT) E-42
E.1.27 Deliverable 6.5 – Operational Readiness Test Report E-43
E.1.27.1 Assessment of Operations Tested E-43
E.1.27.2 Impact of the Test Environment E-44
E.1.27.3 Recommendation for Improvement E-44
E.1.28 Deliverable 7.1 – Training Strategy E-44
E.1.28.1 Introduction E-44
E.1.28.2 Training Requirements E-45
E.1.28.3 Training Resource Requirements E-45
E.1.28.4 General Content of Training Materials E-45
E.1.28.5 Evaluation E-45
E.1.28.6 Communication Approach E-45
E.1.29 Deliverable 7.2 – Training Plan E-45
E.1.29.1 Introduction E-45
E.1.29.2 Training Methods E-46
E.1.29.3 Training Logistics E-46
E.1.29.4 Training Environment and Resources E-46
E.1.29.5 Training Materials E-46
E.1.30 Deliverable 7.3 – Training Environment E-47
E.1.30.1 Training Environment E-47
E.1.31 Deliverable 7.4 – Training Materials E-47
E.1.31.1 Types of Training Materials E-47
E.1.31.2 Content of User Training Materials E-48
E.1.31.3 Update/Revise Training Materials E-48

E.1.32 Deliverable 7.5 – Training Report E-48
E.1.32.1 Evaluation E-49
E.1.33 Deliverable 8.2 – Production Environment E-49
E.1.33.1 Production Environment E-49
E.1.34 Deliverable 8.7 Implementation Certification Letter E-49
E.1.35 Deliverable 9.1 & 12.1 – Operations Quality Management Plan E-50
E.1.35.1 Scope E-50
E.1.35.2 Plan Quality E-50
E.1.35.3 Perform Quality Assurance E-51
E.1.35.4 Perform Quality Control E-52
E.1.36 Deliverable 9.2 & 12.2 – Fiscal Agent Staffing Requirements Capability Report E-52
E.1.36.1 Approach to Preparing the Report E-53
E.1.36.2 Organization Charts E-53
E.1.36.3 Named Persons E-53
E.1.36.4 Support Team E-53
E.1.36.5 Recruitment and Training E-53
E.1.36.6 Cross Training Staff E-54
E.1.37 Deliverable 9.3 11.3 & 12.3 – Weekly Project Status Report E-54
E.1.37.1 Format and Focus E-54
E.1.38 Deliverable 9.4 11.4 & 12.4 – Annual Status Report E-55
E.1.38.1 Report Content E-55
E.1.39 Deliverable 10.1 – Certification Checklist E-56
E.1.39.1 Certification Approach E-56
E.1.39.2 Certification Checklist Criteria E-56
E.1.40 Deliverable 10.2 – Certification Review Package E-56
E.1.41 Deliverable 11.1 – System Operation & Maintenance Support Plan E-57
E.1.41.1 Scope E-57
E.1.41.2 Production Operation Support E-57
E.1.41.3 System Maintenance Resource Requirements E-58
E.1.41.4 System Enhancement Resource Requirements E-58
E.1.41.5 Activity Tracking and Reporting E-59
E.1.41.6 System Maintenance and Enhancement Processing E-59
E.1.41.7 Technical and Management Reviews E-60
E.1.41.7.1 Joint Technical Reviews E-60
E.1.41.7.2 Joint Management Reviews E-60
E.1.42 Deliverable 11.2 – Staffing Requirements Capability Report E-60
E.1.42.1 Approach to Preparing the Report E-60
E.1.42.2 Organization Charts E-61
E.1.42.3 Named Persons E-61
E.1.42.4 Support Team E-61
E.1.42.5 Recruitment and Training E-61
E.1.42.6 Cross-training Staff E-61
E.1.43 Deliverable 11.5 – System Updates E-62
E.1.43.1 General Process E-62
E.1.44 Deliverable 11.6 – Operations and Maintenance Procedure Manual E-62
E.1.44.1 Account Management Services Overview E-62
E.1.44.2 Enhancement and Modification of the System E-62
E.1.44.3 System Maintenance (Break/Fix) E-63
E.1.44.4 Problem Tracking and Resolution E-63
E.1.44.5 IT Help Desk Services E-64
E.1.44.6 Acquisition Services for Hardware, Software and Third Party Support Services E-64
E.1.45 Deliverable 13.1 – Turnover Plan E-64
E.1.45.1 Content E-64
E.1.46 Deliverable 13.2 – Develop a DMES Resource Requirements Statement E-64
E.1.46.1 Content E-64
E.1.47 Deliverables 13.3 – System Documentation and Source Code Library E-65

E.1.47.1 Content E-65
E.1.48 Deliverable 13.4 – Turnover Results Report E-66
E.1.48.1 Content E-66

F ATTACHMENT F: GLOSSARY OF TERMS F-1

G ATTACHMENT G: PROCUREMENT LIBRARY G-1

H ATTACHMENT H: CURRENT MMIS TECHNICAL ARCHITECTURE H-1

I ATTACHMENT I: STATE RESPONSIBILITIES AND DMES PROJECT TEAM COMPOSITION I-1

I.1 State Responsibilities I-1
I.1.1 Staffing Roles I-1
I.1.1.1 Project Organization Chart I-2
I.1.1.2 State Staff Participation I-2
I.1.2 Resource Availability I-3
I.1.3 Deliverable Review I-3
I.1.3.1 Implementation I-3
I.2 Independent Verification and Validation (IV&V) I-3
I.2.1 IV&V Scope I-3
I.2.2 State Responsibilities for IV&V: I-4
I.2.3 Prime Responsibilities for IV&V I-5

J ATTACHMENT J: DELAWARE MEDICAID BENEFIT PLANS AND WAIVER SERVICES J-1

K ATTACHMENT K: COST PROPOSAL K-1

L ATTACHMENT L: CONTRACT TERMS AND CONDITIONS L-1

L.1 Terms and Conditions L-1
L.1.1 Contract Composition L-1
L.1.2 Payment for Services Rendered L-1
L.1.3 Contract Term L-1
L.1.4 Contractor Personnel L-2
L.1.5 Funding L-2
L.1.6 Confidentiality L-2
L.1.7 Method of Payment L-2
L.1.8 Contract Transition L-2
L.1.9 Tardiness Sanction L-3
L.2 General Terms and Conditions L-3
L.3 State of Delaware Cloud and Offsite Hosting Specific Terms and Conditions L-8
L.4 Acknowledgement of Terms and Conditions L-15
L.5 DHSS Standard Contract L-16
L.6 Criminal Background Check Instructions L-25
L.7 Performance Based Contracts and Damages for Systems Contractors L-27
L.7.1 Performance Standards and Quality Management L-27
L.7.2 Performance Based Contracts and Damages for Vendors L-27
L.7.2.1 Approach to Reporting L-27
L.7.2.2 Actual and Liquidated Damages L-27
L.7.2.3 Right to Assess Damages L-27
L.7.2.4 Dispute Resolution Process for Damage Assessments L-28
L.7.2.5 Performance Measures, Service Level Agreements, and Damages L-28
L.7.2.6 Quality Management Performance Standards L-29

L.7.2.7 Implementation and System Architecture Performance Standards L-30
L.7.2.8 Certification and HIPAA Compliance Performance Standards L-31
L.7.2.9 Staffing and Key Personnel Performance Requirements L-32
L.7.2.10 Call Center Operations Performance Requirements L-33
L.7.2.11 Provider Enrollment Performance Requirements L-34
L.7.2.12 AVRS Performance Requirements L-35
L.7.2.13 Claims Processing Performance Requirements L-36
L.7.2.14 Mail Room Performance Requirements L-38
L.7.2.15 ARRA Performance Requirements L-38
L.7.2.16 Reporting Performance Requirements L-39
L.7.2.17 System Availability Performance Requirements L-39
L.7.2.18 System Response Time Performance Requirements L-40
L.7.2.19 System Maintenance and Support Performance Requirements L-42
L.7.2.20 Business Continuity and Disaster Recovery Performance Requirements L-43
L.7.2.21 Banking and Finance Operations Performance Requirements L-45
L.7.2.22 Failure to Notice Performance Requirements L-48
L.7.2.23 EDP Audit Performance Requirements L-49
L.7.2.24 CMS Sanctions Performance Requirements L-50
L.7.2.25 System Documentation Performance Requirements L-50
L.7.2.26 Project Deliverables Performance Requirements L-50
L.7.2.27 Key Dates Performance Requirements L-51
L.7.2.28 Minimum Cycles/File Update Processing Performance Requirements L-52
L.7.2.29 Other Contract Provisions Performance Requirements L-53
L.7.2.30 Medicare Premium Payments Performance Requirements L-54
L.7.2.31 Pharmacy Drug Rebate Performance Requirements L-54
L.7.2.32 Unexpected Costs Performance Requirements L-54

M ATTACHMENT M: HIPAA COMPLIANCE MATRIX M-1

N ATTACHMENT N: PERSONNEL – MINIMUM QUALIFICATIONS, ROLES, AND RESPONSIBILITIES N-1

O ATTACHMENT O: CERTIFICATION AND STATEMENT OF COMPLIANCE O-1

P ATTACHMENT P: MANDATORY SUBMISSION REQUIREMENTS CHECKLIST P-1

Q ATTACHMENT Q: DELAWARE CONTRACTS DISCLOSURE FORM Q-1

R ATTACHMENT R: BIDDER'S SIGNATURE FORM R-1

S ATTACHMENT S: OFFICE OF MINORITY AND WOMEN BUSINESS ENTERPRISE CERTIFICATION TRACKING FORM S-1

T ATTACHMENT T: BIDDER PROJECT EXPERIENCE T-1

U ATTACHMENT U: DELIVERABLE ACCEPTANCE REQUEST FORM U-1

V ATTACHMENT V: BIDDER CONTACT INFORMATION V-1

W ATTACHMENT W: NAMED STAFF RESUME W-1

X ATTACHMENT X: PERSONAL REFERENCE FORM X-1

A ATTACHMENT A: GENERAL INFORMATION

A.1 DHSS Program Overview

The mission of Delaware Health and Social Services (DHSS) is to improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations. DHSS is comprised of 12 divisions as follows:

- Division of Substance Abuse and Mental Health.
- Division of Child Support Enforcement.
- Division of Long Term Care Resident Protection.
- Division of Management Services.
- Division of Developmental Disabilities Services.
- Division of Public Health.
- Division of Services for Aging and Adults with Physical Disabilities.
- Division of Social Services.
- Division of Medicaid and Medical Assistance.
- Division of State Service Centers.
- Division for the Visually Impaired.
- Office of the Chief Medical Examiner.

A.2 The Division of Medicaid and Medical Assistance

The mission of the Division of Medicaid and Medical Assistance (DMMA) is to improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost effective manner.

DMMA provides comprehensive medical assistance to approximately 230,000 individuals each month who are eligible for one of Delaware’s Medical Assistance Programs (DMAP) administered by DMMA.

DMMA is organized into the following areas of responsibility: Policy and Program Development; Program Integrity; Medical Management and Delegated Services; Training and Long-Term Care Medicaid Programs (LTC) Eligibility Services; Information Systems and Financial Management.

DMMA currently contracts with Hewlett Packard Enterprise Services (HPES) to provide Fiscal Agent (FA) services. The FA operates and maintains the Medicaid Management Information System (MMIS) and performs claims processing and related functions for all the DMMA programs and also for the following programs operated by other DHSS divisions: Part C of the Individuals with Disabilities Education Act (IDEA), the Delaware Cancer Treatment Program, and Non-Medicaid Immunizations. In addition to claims processing, the following functions are also performed by HPES under the FA contract: pharmacy consultant services, a client pharmacy call center, provider relations, preferred drug list and supplemental drug rebates, Delaware Prescription Assistance Program (DPAP) enrollment and coordination with Medicare Part D, ePrescribing, Third-Party Liability (TPL) verification and lead processing, Drug Utilization

Review (DUR), drug supplemental rebates, processing of premiums for the Delaware Healthy Children Program and the Medicaid for Workers with Disabilities eligibility category, and maintenance of an ad hoc query environment management. DMMA also has a separate contract with HPES to perform the independent managed care enrollment broker function required under 42 CFR 438.10(b) and 438.810(b).

A.3 Fiscal Agent Support Services

HPES is the current Delaware Medicaid FA and operates and maintains the Delaware MMIS on behalf of the state. HPES plays a significant role in performing the daily operational business functions of the DMAP program supporting a small DMMA staff (as compared to larger states). Under the existing contract, the FA services include the following:

1. Process and adjudicate claims in the Health Insurance Portability and Accountability Act (HIPAA) complaint electronic transaction formats including pharmacy Point of Sale (POS).
2. Supports other HIPAA compliant transactions such as the 834 Roster file and 820 premium payment files necessary for managed care operations.
3. Provide remittance advices.
4. Provide pharmacy consultant services (Drug Utilization Review (DUR), Prospective Drug Utilization Review (Pro-DUR) and Preferred Drug List (PDL).
5. Support ePrescribing processes.
6. Perform supplemental drug rebate invoicing and reconciliation.
7. Operate a client and provider pharmacy call center to assist with the PA process and to provide assistance in resolving requests regarding use of the drugs on the preferred drug list, generics, prior authorizations, quantity limitations, drug utilization review, and eligibility.
8. Operate a provider call center and perform provider relations functions including enrollment.
9. Support Provider EHR Provider Incentive Payments using the Medical Assistance Provider Incentive Repository (MAPIR).
10. Provide Third Party Liability (TPL) verification and lead processing.
11. Perform eligibility determination and processing for the Delaware Prescription Assistance Program (DPAP).
12. Provide Health Care Program Premium processing for the Delaware Healthy Children Program (DHCP) and the Medicaid for Workers with Disabilities eligibility group.
13. Provide banking services.
14. Support an ad hoc query environment.
15. Accept batching of pharmacy POS health care claims and claims via the internet from Electronic Claims Management Systems (ECMS).

All of these supporting business roles are discussed in detail later in this section.

The FA manages computer systems and networks located at multiple locations. The primary operational and development site for the Delaware MMIS is in Newark, Delaware. It houses staff, systems, and equipment used to support multiple operational aspects of the MMIS.

A.3.1 Fiscal Agent Services Provided to DMMA

The fiscal agent is primarily responsible for executing the operations of the Delaware MMIS on behalf of the State, and has the authority to process and pay claims and execute other financial management functions of the Medicaid program. The fiscal agent in some instances also has the responsibility of developing, designing, implementing, and maintaining the MMIS on behalf of the State. The fiscal agent also works closely with the State to ensure the systems required to administer the Medicaid program on behalf of the State are running at optimal capacity. Following is a detailed description of core services provide by the fiscal agent in support of DMMA and the Delaware Medical Assistance Program.

A.3.1.1 Claims Adjudication

The fiscal agent supports the claims adjudication and edit/audit processing functions to ensure that claim records are processed in accordance with State policy. This processing includes application of non-history-related edits and history-related audits to the claim. Claims are screened against data in the MMIS such as member, provider, reference (e.g., procedure, drug, and diagnosis), pended and adjudicated claims, and all edit/audits. Those claims that do not satisfy program or processing requirements are denied or suspended and fiscal agent claims resolution staff is responsible for resolving suspended claims according to the State-specified method of correction.

A.3.1.2 Claims Control and Entry

The fiscal agent supports the claims control function by monitoring and tracking claims and related input from receipt to final disposition within the Delaware MMIS. Control over all claims transactions maintains the integrity of the data that is entered and processed. Both manual and automated procedures are used to provide claims control and claims control reporting. The claims entry function supports the acceptance of claims using hardcopy and electronic media (both fee-for-service (FFS) and encounter claims) into the MMIS and ensures the accuracy, reasonableness, and integrity of MMIS entered data for processing. DHSS has contracted with the fiscal agent to provide the McKesson Claim Check® product.

A.3.1.3 Client

The primary purpose of the Client Business Area is to accept and maintain an accurate, current, and historical source of eligibility and demographic information on individuals eligible for medical assistance in Delaware, and to support analysis of the data contained within the Recipient Data Maintenance subsystem. Recipient Data Maintenance is the terminology embedded in the current MMIS.

The maintenance of client information is required to support eligibility verification, claim processing in batch and online mode, reporting functions. Client related data is also described and utilized in other business areas such as Third Party Liability (TPL), Long Term Care (LTC), Managed Care (MC), Early Periodic Screening, Diagnosis, and Treatment (EPSDT), Management and Administrative Reporting (MAR), Surveillance and Utilization Review (SUR), and Prior Authorization (PA). The current source of eligibility data for the MMIS is a daily file extract from Delaware Client Information System II (DCISII), the State's eligibility system.

A.3.1.4 Drug Rebate

Federal law, regulations, and DHSS policy require for drug labeler, with whom the Centers for Medicare & Medicaid Services (CMS) has a formal agreement rebates determined by the volume of the labeler's products covered by the program. The Drug Rebate process recovers money from drug labelers whose drugs are used by DMMA clients that are enrolled in Medicaid, DHCP, or one of the state's prescription assistance programs (DPAP, DCTP, or CRDP). Drug labelers send CMS quarterly updates containing current National Drug Codes (NDCs), rebate-per-unit amounts, and labeler information. The fiscal agent has direct access to the CMS Drug Data Reporting (DDR) for Medicaid systems and uses it to update the unit rebate file and Drug Labeler information file. The fiscal agent combines the CMS information with the multi-state supplemental rebate data. The fiscal agent then extracts paid claims with an outpatient drug component from claims history to produce Federal, Supplemental, DHCP, SPAP, and encounter invoices for drug labeler with any drug claims paid during the quarter and any outstanding invoice balances.

A.3.1.5 Drug Utilization Review

Prospective Drug Utilization Review (Pro-DUR) is a series of alerts incorporated into an online, real-time pharmacy claims processing system. This feature provides immediate feedback to pharmacies regarding the prescription, medical history, and age information of Medicaid clients. The Pro-DUR system compares this information against predefined criteria to determine if a potential therapeutic problem will exist if the prescription is dispensed. Retrospective Drug Utilization Review (Retro-DUR) monitors historical paid claims data to identify patterns of inappropriate medication use by clients, pharmacists, and prescribers. Trend analyses from Retro-DUR can decrease unwarranted or unnecessary expenditures by providing post-payment utilization data and intervention upon discovery of inappropriate patterns of drug use.

A.3.1.6 ePrescribing

The current fiscal agent has established a collaborative relationship with an ePrescribing software vendor and an integrator/translator vendor to facilitate the exchange of client eligibility, medication history data, benefit coverage, and rules from the MMIS to the prescriber at the point of prescribing. Once coverage and clinical issues are resolved, practitioners can transmit prescription information electronically to the client's pharmacy of choice via connections between the prescriber's office and pharmacies.

A.3.1.7 Electronic Verification System

The EVS system provides eligibility verification services to all DMAP providers. The EVS is a collective term that includes many access methods including Internet-based technologies, the DMAP website, an Automated Voice Response System (AVRS), the Electronic Claims Management Service (ECMS), which allows for the drop-off and pick-up of data in HIPAA standard formats, POS systems, and software/approved third-party vendor software for claim submission. Components of the EVS are:

1. Internet-based EVS: An interface to the MMIS utilizing Internet-based technology that allows for verification of client coverage and other services through a secured Internet website.
2. Telephone/Voice-based EVS: An interface to the MMIS using voice response hardware and software. The AVRS is an automated system accessed by touch-tone telephone to

provide information regarding client eligibility and other coverage in addition to other verification services.

3. Electronic Claims Management Service (ECMS): An interface to the MMIS that allows for the drop-off and pick-up of data in HIPAA standard formats.
4. POS Systems: Electronic messages submitted interactively (as opposed to batch, through a POS device or through personal computer (PC)-running, POS emulation software), allow providers to interface with the MMIS through ECMS and obtain current eligibility and other coverage. Providers may also use magnetic swipe eligibility cards in conjunction with their POS systems to obtain current eligibility and other coverage.
5. Provider Electronic Solutions software/approved third-party vendor software: A software package that allows providers to access verification services and claims submittal using a computer. These transactions interface with the MMIS through ECMS.

A.3.1.8 Financial

The fiscal agent is responsible for processing and tracking financial activity using the financial functions within the MMIS. All money going into and coming out of the system is processed and tracked by program or fund source including; claim payments, capitation payments, claim adjustments, premium billing, premium payments, cash receipts, refunds, financial payouts, accounts receivable (AR), and system-generated transactions for all accounts. Accounts in the Delaware MMIS include providers, clients, carriers, and drug manufacturers.

The fiscal agent is also responsible for operating and maintaining banking functions including: account reconciliation, security, printing of manual checks, electronic funds transfer (EFT), and other financial transactions, all in support of the payment of Medicaid claims to providers on behalf of the State.

A.3.1.9 Electronic Health Records (EHR) Incentive Payment Program

DMMA launched the EHR Incentive Program on November 8, 2011 as a result of the Health Information Technology for Economic and Clinical Healthcare (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, Section 4210. Eligible Providers (EPs) and Eligible Hospitals (EHs) who wish to receive EHR incentive payments must register for the Medicare and/or Medicaid programs through CMS' National Level Repository (NLR), a nationwide database of registered providers. The NLR will send a daily file to each State containing the providers who registered under that State's Medicaid program. The State is responsible for verifying that EPs and EHs meet the registration requirements and for responding to the NLR.

After the EPs and EHs register with the NLR, they will apply for the EHR incentive payment and attest to meeting eligibility and meaningful use requirements (e.g., patient volume, certified EHR technology). EPs are eligible to receive a total of six payments, one per payment year. EHs in Delaware will receive payments spread over 3 years as they attest to higher levels of meaningful use each year. States are responsible for taking provider application and attestation information as well as verifying that the EP or EH meets the CMS requirements for payment. Ultimately, the states must calculate the EHR incentive payment amounts and process the payment requests. All EHR incentive payment activity must be tracked and reported back to CMS through the NLR.

States are also responsible for creating a process that allows the EPs and EHs to appeal the State's decisions on program eligibility, payment amounts, and determination of meaningful use.

In addition, states are responsible for monitoring, verifying, and periodically auditing the provider's requirements to receive the EHR incentive payment.

MAPIR is a web-based application developed using MITA principles. The application has a provider-facing component and a user support component for operational administrators and users. MAPIR is configurable to enable States to process State-specific requirements as permitted by current and future regulations. The Delaware application was customized with a number of reports to track the incentive payments for CMS 64 quarterly reporting. The integration of the MAPIR application into the Delaware MMIS and DMAP website offered a solution that reduced implementation time and costs.

The core MAPIR application supports these functions:

- Eligibility confirmation for professional providers and hospitals
- Attestation requirements
- Suspense processing
- Updates received from the NLR
- Appeals tracking
- Issuance of incentive payments
- Data storage

The system is designed to interface with the MMIS receiving provider enrollment and claims information, creating transactions for payment within MMIS, and storing payment information (check date, payment date) within MAPIR. An MMIS provider drop-down menu allows query of applications in process and allows for tracking by a cash transaction number.

The MAPIR application or its functions must be continued until 2021 in order for payments to be issued to EPs either through an extended licensing agreement or an alternative solution. In addition, Delaware's current fiscal agent provides operational support for the EHR Incentive Program through a Provider Incentive Payment team. This team manages the MAPIR system and EP and EH enrollment; provider calls and emails; provider events; pre and post payment audits; and assists in system tests and web updates related to the EHR Incentive Program. The fiscal agent's systems engineers maintain and update MAPIR/MMIS versions and install defect patches and releases.

A.3.1.10 Management and Administrative Reporting

The fiscal agent supports the provisioning of programmatic, financial, and statistical reports using the MAR business area in the MMIS. The reports are used to fulfill the State's federal reporting responsibilities and to assist the State and federal government with fiscal planning, control, monitoring, program and policy development, and evaluation of the DMMA programs. MAR produces numerous reports on the Delaware medical programs and other State program functions with information extracted at the detail level from the Claims, Provider, Client, Reference, and Financial business areas.

A.3.1.11 Managed Care

The Managed Care business area supports the delivery of healthcare services to Medicaid recipients through a managed care delivery system. It maintains managed care enrollment

information and provides for the payment of capitation and FFS claims for clients enrolled in managed care.

A.3.1.12 Prior Authorization

HPES provides and supports PA functions which offer the State a mechanism to review, assess, pre-approve, and/or deny selected non-emergency medical services prior to actual delivery. These mechanisms and processes are coordinated through the PA Request processing function. Online screens allow real-time entry and update of PA transactions and provide inquiry access to the PA database. The PA request process involves the maintenance of PA data, as well as real-time access and reporting capabilities. The fiscal agent supports the following four PA business functions:

1. Update and maintain PA requests: Allows authorized users to update and maintain PA data as needed. The functionality involves the receipt of PA requests from providers or a member of non-provider community, a response to the requestors, and updated information in the MMIS. Providers may submit a PA request via one of two ways; electronically in X12 278 formats, or in the case of providers and members of the non-provider community, request a PA by sending in a paper request or by phone, which is manually entered into the system. All PAs entered into the system are manually reviewed prior to approval or denial.
2. Generate PA Notices: The business function supports written communication between the State, HPES, providers, and clients regarding their PA requests using PA data, client data, and provider data to build the notices and reminders. Notices are sent to requestors and clients (e.g., reminder notices related to expiration of limits on quantity or duration of a PA). The legal description for the fair hearings process is attached to each of the client notice. Notices and letters produced by the PA system are tracked using a unique letter tracking number, which is printed at the top of the letter. Tracked notices and letters are accessible via an online screen.
3. Access PA data: providers have online inquiry access to the status of their PA requests through the PA Status Inquiry Internet Website. The PA online function provides inquiry, add, and update access to the PA data stores on the system through various screens to support the provider community.
4. Produce PA reports: The fiscal agent provides summary data and groupings of data that are suitable for reports used to administer the PA process for the Medicaid program. Reports are generated to monitor the progression of the PA process by producing information on PAs in approved, denied, pended, appealed, closed, and exhausted status and the frequency of these statuses. More reports are generated to monitor the cost savings, PA usage detail, and PA entry timeliness.

A.3.1.13 Provider

The Provider business area is divided into the following functional process areas:

1. Provider Enrollment process area focuses on recruiting potential providers, enrolling the provider, screening providers as mandated by the ACA, maintaining information on the provider, training the provider, and communicating with the provider community. The goal of this business area is to maintain a robust provider network that meets the needs of both members and provider communities.

2. Provider Data Maintenance process area maintains comprehensive, current, and historical information about providers eligible to participate in DMAP programs. The establishment and maintenance of a single provider data repository with provider demographic, certification, rate, and summary financial information, supports accurate and timely claim records processing, enhanced management reporting, and utilization review reporting and surveillance activities.
3. MAPIR is a web-based application that supports NLR interfaces and data exchanges and state requirements for determining and issuing eligible provider incentive payments. The application has both a provider facing and a user support component.

The Delaware MMIS utilizes the National Provider Identifier (NPI) as the identification number of record.

A.3.1.14 Reference Data Maintenance

The Reference Data Maintenance business area maintains a consolidated source of reference information that the MMIS uses during performance of other functions, including all claims and adjustment processing functions, PA, and Third Party Liability (TPL) processing. The Reference business area is responsible for editing and reporting all data used to edit/audit claims data, to price claims, and to maintain security within the MMIS.

A.3.1.15 Surveillance and Utilization Review Subsystem

The SUR business area incorporates those business activities that focus on program compliance (e.g., auditing and tracking medical necessity and appropriateness of care and quality of care, fraud and abuse, erroneous payments, and administrative abuses).

The SUR function supports the investigation of potential misuse by providers of DMAP programs. Historical data is analyzed and a profile of normal health care delivery is created, after which users (either clients or providers) whose patterns of care or utilization deviate from established normal patterns of health care delivery, are listed on medical review reports. This function serves as a management tool to allow the State to evaluate the delivery and utilization of medical care, on a case-by-case basis, to safeguard the quality of care, and to guard against fraudulent or abusive use of Delaware Medicaid Programs.

A.3.1.16 Third-Party Liability

Medicaid programs are required to ascertain the legal liability of third parties and exhaust such payment sources prior to payment of claims or recover such funds after the fact in certain cases.

Cost avoidance is a function performed by the current legacy system and cost recovery is contracted out to a third-party vendor.

A.3.1.17 DMAP Website

The DMAP website allows providers to inquire on client eligibility, enter a PA, check PA status, look up check-write information, view NDC codes, utilize POS authorization for pharmacy claims, and inquire on claim status and view provider fee schedules, in addition to retrieving forms, manuals, and bulletins. The EVS is a collection of functionalities which allows for these inquiries through the website. This business area of the MMIS distributes essential information to providers. Methods for accessing and the information returned vary, but all are included in the Eligibility Verification Systems (EVS) business area.

The DMAP website at www.dmap.state.de.us is maintained by the Delaware fiscal agent. The DMAP website uses an Open Servlet Engine (OSE) Remote configuration to process all web transactions, both static pages and dynamic/interactive content. Providers with an NPI and Taxonomy may use the DMAP website to get check-write information, inquire on client eligibility, enter a PA, check PA status, view NDC codes, and inquire on claim status.

A.3.1.18 Health Benefits Manager

The State separately contracts with a Health Benefits Manager (HBM) to perform outreach and other client services for managed care enrollment. The fiscal agent must be capable of pre-assigning clients into a managed care plan at the direction of the state."

The HBM Member Services Team assists Medicaid and DHCP clients in selecting a health plan that will meet their needs and in enrolling with that plan.

A.3.1.19 McKesson Claim Check®

To comply with the Mandatory State Use of National Correct Coding Initiative (NCCI) effective for claims filed on or after October 1, 2010, DMMA contracted with the fiscal agent to provide the McKesson Claim Check® product. NCCI is a CMS program that consists of coding policies and edits/audits imposed upon claims processing to achieve accurate coding and to prevent duplicate or overpayments to providers. The State's intention is to continue to use the existing application or similar product to meet NCCI requirements.

A.4 Background and Documentation

Delaware implemented the first HPES MMIS solution on July 1, 1990. CMS granted DHSS a 4-year core contract extension to make allowance for the Year 2000 (Y2K) remediation effort for the Delaware MMIS. This extension from June 30, 1998 to June 2002 also included a 2-year transition period allowing Delaware to pursue a replacement solution for its current MMIS during which DDI work was performed. HPES again, was awarded the MMIS contract (Request for Proposal (RFP) #PSC390) for the replacement MMIS. As a result, the current HPES MMIS is a modified second-generation solution with architecture and functional capabilities that are due for replacement based on current available MMIS technologies, architectures, and best practices. The current MMIS contract ends on June 30, 2016.

DMMA believes the current MMIS must be replaced. Numerous modifications have occurred over the past 11 years since the MMIS was first implemented in 2000. Despite these modifications, the current system cannot meet the new requirements of the CMS Seven Conditions and Standards released in April 2011, and would require more funding for technological modernization than other options analyzed. After considering the advantages, disadvantages, technological implications, and risks, DMMA has decided that the best strategy is to procure a new modular MMIS. The new MMIS will provide Delaware with the flexibility to address: the upcoming health care reform initiatives, the technology investment requirements implemented by CMS, and DMMA's Medicaid increased enrollment.

DMMA believes the selection of a modular MMIS model offers the best approach to a phased or incremental implementation when using: a Service Oriented Architecture (SOA) framework, a Business Rules Management System (BRMS), and an Enterprise Service Bus (ESB). DMMA also believes the model is both a deliberate and conservative approach guarding against implementation risks in the event modularity for specific services has not yet developed. Meanwhile, business services as delivered via the current legacy MMIS will no longer be tightly coupled and will suffice to meet the intent of the Seven Conditions and Standards.

The DHSS, DMMA, under the initial Planning Advanced Planning Document (PAPD), contracted with Cognosante a year prior to the release of the CMS Seven Conditions and Standards.

B ATTACHMENT B: STATEMENT OF WORK

B.1 Statement of Work

The Department of Human Services (DHSS), Division of Medicaid and Medical Assistance (DMMA) desires to select a Contractor to perform a specific set of activities to support the development, implementation, operations and maintenance of the Delaware Medicaid Enterprise System (DMES).

The Statement of Work (SOW) calls for the Contractor to:

- Propose and develop a system using a modular design and interoperable enterprise architecture employing a collaborative teaming approach. The Contractor will provide services required to maintain, enhance and operate the new DMES over the Project Life Cycle (PLC). The replacement system will meet the applicable Medicaid Enterprise Certification Toolkit (MECT) requirements, align with the Medicaid Information Technology Architecture (MITA), and comply with the Centers for Medicare & Medicaid Services (CMS) "Enhanced Funding Requirements: Seven Conditions and Standards." Delaware's functional and technical requirements are identified in Attachment C – DMES Functional Requirements. The Contractor will meet these objectives by executing Tasks 1-8 and 10 within a 30-month period.
- Recommend the integration of best-of-breed existing and proven products rather than the traditional approach to new systems development that includes a state-of-the-art modular framework and supporting services, e.g., rules engine and workflow management, from best-of-breed contractors. (Tasks 1, 2, 3, 4, 5, 6, 8)
- Prepare the DMES for federal certification and to conduct planning activities to assure the new DMES is developed and enhanced to meet the Medicaid Information Technology Architecture (MITA) in Task 10.
- Provide Fiscal Agent Services to operate the DMES for an 11-year period (5 base years and 6 optional years) to meet the operations requirements identified in Tasks 9 &12.
- Provide DMES maintenance and enhancement services for an 11 year period (5 base years and 6 optional years) to meet the operations requirements identified in Tasks 11, 12.
- Provide Medicaid Pharmacy Benefit Management Services to support: drug claims processing, utilization management, drug rebate, pharmacy and call center expertise and needed auditing services in Task 12.

The scope of the DMES requirements includes the following major functionality / modules and system components that are defined in Attachment C – DMES Functional Requirements:

- Work Flow and Document Management Systems (WF/DMS) to support the workflow and scanning of Medicaid paper claims and other documents.
- Pharmacy Point of Sale (POS), Pharmacy Benefit Manager (PBM), Drug Utilization Review (DUR) and Prospective DUR (Pro-DUR) functionality to support the pharmacy claims processing requirements.
- Eligibility Verification System (EVS), including Internet-based technologies, the Delaware Medical Assistance Program (DMAP) website, an Automated Voice Response system (AVRS), and the Electronic Claims Management Service (ECMS) to allow providers to access client eligibility and verification of coverage and claims submittal status.

B.1.1 Contractor Activities

The Statement of Work defines the tasks to be performed by the Contractor to develop and implement a new DMES that meets DHSS requirements including the tasks for Operations (Tasks 9 &12) and Systems Operations and Maintenance Support (Tasks 11 & 12) of the DMES after implementation. The Statement of Work assumes the following:

- The Contractor will modify their proposed Base System to meet the functional requirements defined in Attachment C – DMES Functional Requirements and as specified in Tasks 1 through 12.
- The Contractor will assist DHSS in the development and implementation of new business processes and workflows as defined in Task 3.
- The Contractor will provide DHSS training as defined in Task 7.
- The Contractor will provide Fiscal Agent (FA) services as defined in Attachment C – DMES Functional Requirements, and as specified in Task 9.
- The Contractor will assist the State in the Certification Readiness Effort with planning and expertise defined in Task 10.
- The Contractor will provide Systems Operations and Maintenance Support following DMES Implementation as defined in Task 11.
- The Contractor will provide for POS PBM services following implementation as defined in Task 12.
- The Contractor will provide Turnover services as defined in Task 13.

B.1.2 DHSS General Responsibilities

DHSS general responsibilities are:

- Provide overall project direction and management.
- Review and approve Deliverables.
- Ensure that technical assistance and support are provided in capacity planning, network planning, database and dictionary requirements, and software requirements of any existing (package) or developed systems.
- Establish project organization by meeting with Contractor project management to finalize and document areas of responsibility, personnel reporting relationships, and administrative procedures.
- Establish evaluation mechanisms by setting up procedures for day-to-day control of the Project as defined by the combined DHSS and Contractor project management team.
- Coordinate other DHSS resources as needed to support the development and implementation process.
- Provide information and answer questions at Contractor request.

B.1.3 Contractor General Responsibilities

Contractor general responsibilities are:

- Modify and enhance a Base System to meet the functional requirements defined in Attachment C – DMES Functional Requirements.
- Provide training services for Contractor and DHSS users and Providers as defined in Task 7.
- Provide FA and quality management support services to DHSS and the new DMES that ensure, and maintain the integrity of customer and stakeholder relationships and program performance as defined in Task 9.
- Provide Operate and Maintenance Support for the new DMES and PBM system components as defined in Tasks 11 & 12.
- Provide PBM services to support: drug claims processing, utilization management, drug rebate, pharmacy and call center expertise, and needed auditing services in Task 12.
- Submit written status reports to the DHSS Project Manager as defined in Attachment E – , Deliverable 1.6.
- Obtain DHSS written approval of the Project Plan before commencing work.
- Ensure that deliverables submitted to DHSS meet the deliverable requirements.
- Obtain written approval from DHSS on deliverables before the task will be considered completed.
- Perform internal quality control on deliverables before submission for DHSS review and maintain records of those activities.
- Provide information and support to the Quality Assurance Contractor involved in the quality assessment of the DMES development and implementation activities.
- Attend meetings and present Project status as directed by DHSS.
- Provide facilities and equipment as defined in B.1.11 and Attachment E, Section 1.1.6.

B.1.4 Project Staffing

A key factor in the success of the project is the degree of collaboration between Project staff, DHSS participants and Contractor staff. The Contractor's Project team will be responsible for performing and supporting the project with quality-related activities described throughout this Section of the SOW. DHSS expects the Contractor to staff the project team with individuals who have expertise to perform or administer the activities.

The Contractor is required to provide Named Staff as described in RFP Attachment P – Requirements Checklist.

In addition, the Contractor must propose qualified, highly skilled project staff. The composition of the project staff will be at the Contractor’s discretion. However, the Contractor must ensure that project staff will meet and retain the performance standards defined in the Project Plan (Deliverable 1.1 and 1.2).

DHSS shall provide a project team consisting of a Project Manager, technical staff, and business analysts representing the business areas throughout DHSS. In addition, part-time participation from other DHSS staff will be available as defined in Attachment I – State Responsibilities and DMES Project Team Composition. The Contractor shall consider these staffing levels when developing the resource management portion of the Project Plan.

The DHSS Project Manager shall be responsible for ensuring that the Project is in compliance with the Contract and satisfies the requirements stated in the RFP. The DHSS Project Manager will consult with the Project Sponsor on a continuing basis on every task of the Project. This coordination will ensure that the new DMES is properly designed, tested and implemented, supports the defined functional and technical requirements contained in the RFP, and is properly documented.

The DHSS Project Manager shall work closely with the Contractor's Project Manager on day-to-day project activities. The Contractor will have full responsibility for providing adequate staff to complete the project in the required time frame.

B.1.5 Project Deliverables

For each project deliverable, a required minimum specification has been defined and is included in Attachment E – Deliverables and Attachment C, Section C.4.1 – Deliverable Standards. All deliverables will be delivered and maintained online in the Project Repository as defined in Attachment E Deliverable 1.5. The Project Repository is the central location for the delivery, management and maintenance of all artifacts of the Project, including all deliverables. The DHSS Project Team will have continuous access to the Project Repository to review and accept deliverables and to provide ongoing management of the project. The schedule for the submission of deliverables is defined in each SOW Task. If a due date contained in the deliverable tables at the end of each SOW Task in Attachment B – Statement of Work is left blank, then the delivery will be based on the Contractor's approved Project Plan.

In the process of developing deliverables, the Contractor will involve the DHSS Project team and the QA Contractor in a review of a draft version of the deliverable. Prior to submission of the draft document, the Contractor's review process will incorporate the Contractor's Internal Quality Management review steps described in the Contractor's Project Plan. As each deliverable is formally submitted, the Contractor shall provide evidence to show that the Contractor's review and corrective action has been followed through the versioning process.

All deliverables will be delivered to the DHSS Project Manager. Deliverables will be delivered in the following format:

- Cover letter, plus
- One hard copy bound,
- One electronic file of the Deliverable on the Project Repository, and
- One electronic file copy on Compact Disk in MS Word, MS Excel, Visio, MS Power Point, MS Project, or other formats as pre-approved by DHSS and as applicable.

Upon receipt of a deliverable, DHSS will log the deliverable and convene a review panel to initiate the review process. DHSS will simultaneously provide Contract deliverables to the Quality Assurance (QA) Contractor for its independent review. As necessary, the Contractor may be asked to provide a walk-through of each deliverable to aid the review panel and the QA Contractor in understanding the document. DHSS and the QA Contractor shall review deliverables to determine their readiness for use and compliance with content requirements specified in Attachment E - Deliverables. DHSS will complete its review and provide review results in writing to the Contractor within 15 days. If DHSS finds deficiencies in deliverables, it will formally communicate them in writing to the Contractor. The Contractor shall correct deficiencies and resubmit corrected deliverables for review within 10 days from receipt of DHSS notification of deficiencies (which begins a new 15 day DHSS review cycle). Deliverables must be approved in writing by DHSS to be considered final.

B.1.6 Role of QA Contractor

The QA Contractor ensures that the Design, Development, and Implementation (DDI) Contractor applies best practices in project management and delivers technical work products that meet DHSS requirements with respect to schedule, cost, functionality, reliability, security, and other quality standards. The QA Contractor shall perform five primary tasks:

1. Project Management (PM), as it relates to the QA Contract.
2. Quality Control (QC).
3. Quality Assurance (QA).
4. Independent Verification and Validation (IV&V).
5. Risk Assessment and Issue Management.

A copy of the Quality Assurance Statement of Work is included in the Medicaid Enterprise System Independent Verification and Validation Services RFP# HSS-13-013 is included in the procurement library.

While the DDI Contractor is primarily responsible for testing its work products, the QA Contractor, under the QC Task, will monitor all aspects of the DDI Contractor's testing activities; including but not limited to the development of test plans, the execution of test plans, and the evaluation of test results. Under the Independent Verification and Validation Task, the QA Contractor will also conduct independent testing of the DDI Contractor's work products on a sampling basis. Under the Risk Assessment Task, the QA Contractor will identify and assess project risks and issues and make recommendations to DHSS regarding possible actions. Under the QA Task, the QA Contractor will independently evaluate all management processes and make recommendations to DHSS regarding process improvement.

B.1.7 Implementation Strategy

In the Project Plan (Deliverable 1.1) the Bidder will propose an implementation schedule that will include the Contractor's recommended phased approach of implementing DMES modules and system components before the required full implementation date. As a result, the development and implementation deliverables identified in Tasks 2 through 8 may be developed and delivered in module or system component parts. The Contractor is required to develop and implement the Work Flow and Documentation Management System (WF/DMS) defined in SOW Attachment C – DMES Functional Requirements within 12 months of Contract start. Therefore, for the WF/DMS, the deliverables in Tasks 2 through 8 will need to be developed for these system components separately, as part of the complete system documentation.

B.1.8 Onsite Staffing Requirement

Generally, Contractor staff is required to be onsite at the Delaware facility. The following Named contractor staff are required to be onsite at the Delaware facility:

- Project Director, as required.
- Project Manager (at least 80% of the time).
- Deputy Project Manager (100% onsite commitment).
- Project Management Office (PMO) Manager (at least 80% of the time).
- Core Medicaid Enterprise Systems Manager (100% onsite commitment).

- Systems Development Manager for Design and Development (at least 80% of the time).
- Fiscal Agent Manager (100% onsite commitment).
- Systems Integration Manager (at least 80 % of the time).
- Pharmacy Services Manager (at least 80 % of the time).
- Implementation Manager (at least 80% of the time).
- Data Conversion Manager (at least 60% of the time).
- Quality Assurance Manager (100% onsite commitment).

The State and the key contractor staff will work very closely together on this project. This requires an onsite presence. It is vital for the contractor project manager and key staff to play an active onsite role in the project and be visible and accessible.

B.1.9 Offsite Project Work

The State will permit project work to be performed offsite, within the United States. For offsite work, the State requires strong management of the resources and assigned tasks; adequate, timely and accurate communications and completion of assigned work by specified deadlines. This is important to any offsite relationship. If the bidder organization is proposing offsite project work, the bidder must specifically address each of the bulleted items below in this section of the proposal. Otherwise, Bidder will respond to this section as follows: **"No offsite project work proposed."**

Note: For the purposes of this section, the bidder staff organization includes subsidiary contractors.

- Provide a detailed description of work to be completed offsite along with a breakdown of the type of work to be provided onsite. Quantify this by estimating for each of the deliverables identified in this Section, the percentage of work to be done offsite.
- Provide an organization chart with job titles of offsite staff and their relationship to the bidder.
- Provide a description of what tasks each job title is responsible for performing.
- Clearly identify if offsite work is to be performed by bidder staff or sub-contractors.
- For offsite subcontractor or bidder staff, please include the names and resumes of key staff, highlighting prior participation on similar projects. Also, provide named or sample resumes for lower level staff.
- Provide a detailed plan for managing offsite work including communication strategy to accommodate time differences if any. Include contingency plan for completing work should offsite relationship be terminated.
- Propose a meeting schedule for project status discussions with offsite management staff.
- Identify the offsite single point of contact who will serve as the project manager of offsite resources. Describe how this project manager and the onsite project manager will interact. The State prefers that the offsite project manager be a bidder employee. Please refer to RFP Section 4.1 for normal bidder staffing requirements.

- Provide a contingency plan for substituting onsite staff if offsite relationship becomes problematic as determined by the State.
- Provide a description of prior bidder organization experience with use of offsite bidder staff or subcontractors and provide U.S. client references for that work.
- Provide a detailed description of proposed project manager's experience in directing offsite staff and/or subcontractors.
- Describe your understanding that the State will only provide management of this project and bidder resources through the onsite project manager. All management/relationships with offsite resources, whether bidder staff or subcontractors, will be handled by the respective bidding organization.
- Describe how the system components will be tested and staged during customization/development. For non-ASP solutions, the State requires that the all UAT, production and related environments be located at the Biggs Data Center. All system components of these environments including all system libraries and databases will be located in the data center as well. State staff must approve the results of system testing before systems components are migrated into UAT. It is critical that system components are proven to operate in the Biggs Data Center UAT environment before hand off to the users for testing. Remote developers and testing staff may access these environments through VPN.

B.1.10 Offshore Project Work

The State will not permit project work to be performed offshore.

B.1.11 Facilities and Equipment

The Contractor will maintain its facility in Delaware within a radius of 15 miles from the New Castle, Delaware DHSS Building, located at 1901 North DuPont Highway locally with access for designated State staff. The Contractor will provide access 24 hours a day, 7 days a week (24x7) to all Contractor Medicaid Enterprise facilities and operations in Delaware and to each Medicaid employee designated by the State, without prior notice, admission, escort, or other requirements. All Contractor and State staff and visitors must wear identification badges at all times while in the facility. The State and the Contractor will establish appropriate protocols to ensure that physical property/facility security and data confidentiality safeguards are maintained. Access to any non-Delaware facility used to support Medicaid Enterprise will be granted within five workdays of the request.

The Contractor will identify the location of all Work to be accomplished for Tasks 1through 12 in the Facilities and Equipment section of the Project Plan, Deliverable 1.1. At a minimum, the following Work will be accomplished in the Contractor’s facility in New Castle, Delaware (some training to occur in other locations in Delaware, to be determined):

1. Coordination of the Project Plan.
2. Status Reports, walkthroughs of deliverables and required meetings with DHSS staff including DDI activities.
3. Data conversion planning meetings with DHSS staff.
4. Acceptance Testing events involving DHSS staff.
5. Training planning and training events involving DHSS staff.

6. Provider implementation planning and execution involving DHSS staff.
7. Certification activities involving DHSS and CMS staff.
8. Operations in Task 9.
9. System Operations and Maintenance Services in Task 11.
10. .Pharmacy Benefits Management Service in Task 12.
11. Turnover Task 13.

B.1.11.1 DDI Phase Requirements

The facility must house and accommodate DDI Contractor staff; DHSS designated staff, and the staff of the QA Contractor hired by DHSS under the Medicaid Enterprise System Independent Verification and Validation Services RFP # HSS-13-013. The Contractor will handle all facility management activities related to the area designated for the state staff.

The facility will support the training room needs called for in B.1.18 and Attachment E - Deliverables, Section 1.1.6. The facility will support the staffing requirement for DHSS designated staff and QA Contractor staff (20 total). The Contractor will be responsible for providing sufficient free parking for all staff, plus 15 visitor spaces.

The Contractor's Facility and Equipment Plan will identify the proposed location for the DMES development, test, and training environments tasks (Tasks 1 through 7). The Facility and Equipment Plan shall also address other key elements including security requirements and provisions for telecommunications for remote work (if applicable).

The Contractor will provide desks, PC/workstations and software with internet access, phones, and printers for sole use by the State designated members and the QA Contractor when working at the contractor facility. The QA Contractor will provide PCs for their own staff. Space for archiving paper documents related to PMO and IVV activities will also be made available in close proximity to the area that accommodates State and QA Contractor staff for the duration of the project.

PCs/workstations shall be standard, commercial quality, sized to the expected project needs and new. All items can be purchased, rented or leased. (All furniture and rented, leased, used or reconditioned items must have prior DHSS approval.)

The Contractor will identify their PC requirements as part of their plan and the PCs will be at a minimum compliant with DHSS published PC standards (Reference Department of Technology and Information website for DHSS PC Operating Standards: http://dti.delaware.gov/pdfs/pp/PCOperatingSystemStandard.pdf). All Contractor PCs that need to be connected to the State LAN/WAN will utilize the DHSS process for obtaining connectivity to Statewide LAN and email.

The Contractor will make accommodation for up to five State-designated staff to support implementation and post-implementation tasks (Tasks 8 through 12) once DDI is completed. The Contractor's Facility and Equipment Plan will reflect the necessary changes for this accommodation prior to inception of the implementation task (Task 8).

All State staff accommodations including facility location, office equipment, telephone and PC, office furniture and fixtures, alarm and access system support standards shall not vary from facility requirements detailed during DDI.

B.1.12 Task 1 – Project Management

This Section presents the requirements for Project Management to be completed over the Contract period for Tasks 1 through 13. Project Management activities span the duration of the Project. Project Management activities that support the use of the Project Plan are the primary control elements on the Project.

The Bidder must submit a preliminary Project Plan with the proposal. As part of the Project Management Task, the Contractor will review the preliminary plan with the DHSS Project management team and update the plan based on this review.

B.1.12.1 Objectives

The specific objectives of the Project Management Task are to ensure that the DMES meets Delaware's specific requirements defined in Attachment C – DMES Functional Requirements and the current CMS functional equivalency and reporting requirements identified in the State Medicaid Manual, Part 11.

The Project Management Tasks are designed to ensure that the Project progresses according to the approved detailed Project Plan. The tasks and associated activities related to Project management are in the following Sections.

The Contractor shall provide an initial Project Plan with the Proposal and will update the plan with DHSS input within 20 days of Project initiation. At a minimum, the Project Plan must include the milestone delivery dates required in this SOW. Once the Project Plan is approved by DHSS, the approved Project Plan will be maintained by the Contractor. The Contractor will modify the Project Plan throughout the Project, with DHSS approval, by updating it to reflect the evolving schedule, priorities, and resources.

As part of the Project Management Task, the Contractor will also provide documentation of systems development processes and controls to be used to ensure a quality DMES development and implementation. The documentation of processes and controls will include a Software Development Plan, Security Policies and Procedures, and the Business Continuity Plan.

The Contractor will prepare and provide a Project Repository. When delivered, it will provide access to Deliverables previously delivered in Task 1 and will host all future Contract Deliverables. The DHSS Project Team will have continual access to the Project Repository.

B.1.12.2 DHSS Project Management Responsibilities

DHSS Project Management responsibilities are to:

1. Provide input and clarifications to the Contractor for developing the Deliverables.
2. Provide access to DHSS policies and procedures related to Contractor Deliverables. When applicable, provide access to appropriate staff to clarify requirements consistent with the DMES Requirements Definition Report.
3. Manage the DMES Project Risk Management Plan and process including periodic input from the Contractor and the QA Contractor.
4. Conduct periodic meetings of the DMES Requirements Management Change Control Board (CCB) in order to manage requirements change requests.
5. Review and approve deliverables.

6. Review and approve project management and status reporting protocols.
7. Purchase PC hardware and software for DHSS staff for use at the State site only.
8. Monitor Contractor performance.

B.1.12.3 Contractor Project Management Responsibilities

Contractor Project Management responsibilities are to:

1. Prepare, submit, gain approval, and execute the Project Plan as defined in Attachment E – Deliverables, 1.1 & 1.2. The Contractor must obtain DHSS approval of the Project Plan before commencing work on the task. At a minimum on a quarterly basis, the Contractor will submit updates to the Project Plan.
2. Present the Software Development Plan and the Change Management Plan to the DHSS Project Team. Utilize the plans during project execution.
3. Prepare and submit Project Status Reports. The Status Reports must be in the format approved by DHSS and include accomplishments, critical issues, personnel utilized, and items planned for the next reporting period. The Status Reports will report identified issues and risks and associated mitigation strategies in support of the DMES Project Risk Management Plan. The Status Reports must conform to the requirements described in Attachment E – Deliverables, Deliverable 1.6, and will be presented to the DHSS Project Manager and the QA Contractor weekly.
4. Establish and begin using the approved Project Repository (Deliverable 1.5) as the control system for all Project Deliverables and other artifacts. Deliverables are expected to be delivered, managed, and controlled through the Project Repository.
5. Participate in the DMES Requirements Management Change Control Board (CCB) as needed.
6. Develop, submit, and utilize the Security Policies and Procedures in Attachment E – Deliverables, Deliverable 1.7 and the Business Continuity Plan in Attachment E – Deliverables, Deliverable 1.8.
7. Attend meetings and present Project status as directed by the DHSS Project Manager.
8. Prepare and submit final deliverables.

B.1.12.4 Personnel Requirements

The following personnel requirements pertain to the Project Management Task. For each project management subtask, the Contractor shall present its approach for determining the staffing requirements to successfully manage all of the project management deliverables through to the Operations Task 9. The minimum Contractor Named Staffing levels required for this task are defined in RFP Section 5.2.14 and below in the Named Staff Section. Named Staff details regarding the minimum expertise and responsibilities of these personnel can found in Attachment N: Personnel – Minimum Qualifications, Roles, and Responsiblities.

Named Staff

The Contractor will be required to provide the following Named Staff for the Project Management Task:

1. Project Director
2. Project Manager

3. Deputy Project Manager
4. Configuration Manager
5. Quality Control Manager

B.1.12.5 Milestones

The critical milestones that affect the schedule or impact progress during the Project Management task are:

1. DHSS approval of the Project Plan deliverables, and the Software Development Plan deliverable.
2. DHSS approval of the Project Repository deliverable.
3. DHSS approval of the Security Policies and Procedures deliverable and the Business Continuity Plan deliverable.
4. DHSS approval of quarterly Project Plan updates.
5. DHSS approval of weekly Status Reports.

B.1.12.6 Deliverables

This section defines the Contractor deliverables related to the Project Management Task. Preparation, maintenance, and use of quality deliverables are critical to the success of the Project Management process and will be used to assess the Contractor's overall understanding of requirements and expectations of DHSS. Documents prepared during the Project Management Task are the foundation for the definition of work to be completed in subsequent Project tasks. Deliverables noted with an asterisk (*) shall be approved prior to commencement of other systems development tasks. The table below also identifies the proposal submission requirements as described in Attachment E – Deliverables that require preliminary Deliverables as a part of the Bidder's response. The deliverables to be provided during the Project Management task are:

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
1.1	Project Plan*	1.1	Yes	Proposal and Contract Start + 20 days
1.2	Project Plan Updates	1.1	No	Quarterly
1.3	Change Management Plan	1.2	No	Contract Start + 20 days
1.4	Software Development Methodology *	1.3	Yes	Proposal and Contract Start + 20 days
1.5	Project Repository	1.4	No	Contract Start + 40 days
1.6	Project Status Reports	1.5	No	Weekly
1.7	Security Policy and Procedures	1.6	No	Contract Start + 60 days
1.8	Business Continuity Plan – Version 1: Development	1 .7	No	Contract Start + 60 days

DHSS review of the Services and Deliverables of this task will ensure that:

1. The Project is managed on schedule, within scope, and within budget.
2. Integrated plans are established and maintained to coordinate a comprehensive list of activities and tasks to handle the breadth of system requirements and the involvement of a large number of DMES stakeholders.
3. Facilities and equipment are procured and established or installed.
4. Integrated plans are established to ensure quality systems development processes are in place to create quality system components.
5. An infrastructure is established to assure that the development, testing, training, and production environments are adequately secure to protect MMIS and data.
6. The Project repository is the means of access and review of MMIS documentation during development and maintenance.
7. Communications are established and maintained that provide adequate progress reporting, problem and risk identification and resolution and Contract management information.
8. The development process allows for internal Contractor quality processes and external independent Quality Assurance activities.
9. Deliverables meet the minimum requirements defined in Attachment E – Deliverables.

B.1.13 Task 2 – Detailed Requirements Analysis

The Detailed Requirements Analysis Task requires analyzing, defining, and further developing business and technical functional requirements that are included in the base system for the new DMES. The requirements must be further refined to arrive at the detailed design requirements that will be traced back throughout the System Development Life Cycle (SDLC) and to the requirements specified in the RFP (Attachment E – Deliverables).

The products of this analysis will serve as the foundation for Detailed System Design documents and the draft version of the System Architecture and Design that will be generated in Task 4. The Requirements Analysis documentation becomes the initial version of the System documentation and will be updated as subsequent tasks are completed.

B.1.13.1 Objectives

The objective of this task is to validate and eventually finalize the requirements for this Project. The outcome of this task is a requirements baseline that will be reviewed and revised in the configuration management process on a continuing basis as requirements are addressed. The Contractor will also be required to identify and document the System business rules to be supported by the new DMES. This task includes the on-going management of the requirements identified in this task.

B.1.13.2 DHSS Detailed Requirements Analysis Responsibilities

DHSS responsibilities for the Detailed Requirements Analysis task are:

1. Provide an Implementation Team of up to 20 full-time individuals with duties that include working with the Contractor to help design the DMES during the Design Phase.

2. Participate in Joint Application Design (JAD) sessions to assist the Contractor in understanding the DHSS role, Contractor role, and requirements for each business function.
3. Review all prototypes, window designs, architecture designs, work plans, requirements documents, and all deliverables and provide quick response and comment.
4. The standard turnaround for DHSS review shall be 10 work days and may be extended if DHSS determines in its sole discretion that it is necessary. DHSS encourages early submission of draft documents to expedite DHSS review.
5. Attend deliverable walkthroughs to enhance understanding and facilitate the approval process.
6. Provide input, interpretation, clarification, and communication of DHSS policies for the Contractor.
7. Manage the DMES Requirements Management process and conduct DMES Requirements Change Control Board Meetings as needed.
8. Review and approve final Deliverables.
9. Monitor Contractor performance.

B.1.13.3 Contractor Detailed Requirements Analysis Responsibilities

Contractor responsibilities for the Detailed Requirements Analysis task are:

1. The Contractor must perform a detailed review and analysis of all requirements provided in the RFP and must develop the detailed specifications required to construct and implement the DMES solution. The Contractor must thoroughly review all appropriate Delaware Medicaid programs and policies and legacy MMIS documentation. The Contractor will work with DHSS staff to fully understand the scope, purpose, and implications of each requirement.
2. Plan and conduct JAD sessions, whose form, structure, timeframe, and schedule are prior approved by the DHSS.
3. Validate and refine the requirements specified in this RFP with DHSS staff.
4. Verify that the capabilities described in the Contractor proposal actually align with and meet the RFP requirements.
5. Validate that the capabilities described in the Contractor proposal meet Medicaid Information Technology Architecture (MITA) requirements.
6. Document the purpose and results of each JAD session.
7. Produce agendas and subject matter expert (SME) rosters for approval by the DHSS prior to distribution.
8. Prepare session minutes for approval by the DHSS prior to distribution.
9. Document and track all action items during sessions.
10. Document the rules in the existing legacy system as appropriate for incorporation into the new DMES rules engines including: benefit plan assignment, pricing rules, and the edit and audit rules.
11. Elaborate and document architectural, and business and technical functional requirements described in this RFP and in attachments for the new DMES.

12. Document and model each business process.
13. Develop acceptance criteria. This measurement will be used to generate the necessary test cases for system and acceptance testing.
14. Support and participate in requirements management.
15. Construct and update the Requirements Traceability Matrix (RTM).
16. Document the requirements validation.
17. Participate with the DHSS Requirements Change Control Board and process as needed.
18. Prepare and submit final Deliverables for approval.

B.1.13.4 Personnel Requirements

The Detailed Requirements Analysis Task marks the beginning of the Design Phase of the SDLC. Together with the subsequent SDLC phases, Development and Implementation, personnel requirements that pertain to these phases are identified. For each DDI subtask identified in Tasks 2 through 8, the Contractor shall present its approach for determining the staffing requirements to successfully manage all of the project management deliverables through to the Operations Task 9. The minimum Contractor Named Staff levels required for this task are defined in RFP Section 5.2.14 and below in the Named Staff Section. Named Staff details regarding the minimum expertise and responsibilities of these personnel can found in Attachment N – Personnel – Minimum Qualifications, Roles, and Responsibilities.

Named Staff

The Contractor will be required to provide the following Named Staff for the DDI Tasks:

1. Core Medicaid Enterprise Systems Manager.
2. System Implementation Manager.
3. Data Conversion Manager.
4. System and Web Architect.
5. Systems Integration Manager.
6. Testing Manager.
7. Database Administrator.
8. System Administrator.
9. Senior Systems Analyst (3), Medicaid SMEs.

B.1.13.5 Milestones

The critical milestones that affect the schedule or impact progress during the Detailed Requirements Analysis task are:

1. Completing the review of documentation pertaining to the legacy MMIS and related processes.
2. Completing the review of business, system, and user requirements documented by DHSS.
3. Completing the detailed requirements analysis meetings with appropriate DHSS staff. This task will be done in parallel with the workflow and process engineering activities in

Task 3. Preparing the requirements baseline document and completion of walk-through with appropriate DHSS staff.

4. Preparation of updated requirements documentation reflecting DHSS comments.
5. DHSS approval of the Detail Requirements Document Deliverable.

B.1.13.6 Deliverables

This section defines the Contractor Deliverables related to the Detailed Requirements Analysis Task. Deliverables noted with an asterisk (*) shall be approved prior to commencement of the Design Tasks.

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
2.1	Detailed Requirements – Requirements System Design *	1.8	No	

DHSS' review of the Services and Deliverables of this task will ensure that:

1. Deliverables meet the minimum requirements defined in Attachment E – Deliverables.

B.1.14 Task 3 – Design

The goal of the Design Task is to develop the logical architecture of the system and support development of detailed programming specifications. Design activities must be consistent with the technical approach presented in the Contractor's Detailed Requirements Analysis.

Implementation plans will be developed during the Design Task to clearly articulate *who* will be responsible, *what* are the various tasks involved, and *how* will they be delivered on time, on budget to meet project expectations. More importantly, the plan must explicitly identify and address implementation challenges and risks and be updated concurrently with each project phase as the project evolves.

Early in the Design Task, the number and scope of test plans will also be determined, and be approved by the DHSS prior to the start of testing. As applicable, test scenarios, test scripts, and test cases within each phase of testing must align with the RTM to verify all requirements are accounted for. Successful test results will confirm all requirements have been thoroughly tested.

In consideration of various testing methodologies of COTS products, stand-alone SOA business modules, or tightly integrated modules, the State is not requiring a specific mandatory approach to testing. However, it is important that any different test methodologies or testing approaches be identified and explained to DHSS before the start of testing.

B.1.14.1 Objectives

The objective of the Design Task is to define the blueprints for the new DMES. Utilizing the detailed requirements deliverable, the Contractor will identify, change if necessary, and finalize the business and technical functional requirements in a design document for the DMES. The design will be used by programming staff to further analyze and construct the services for the new DMES. The Deliverables for this task are a Detailed System Design (DSD) document (Deliverable 3.1) and a System Architecture and Design document (Deliverable 3.3) that contains the required design elements.

The Contractor will be responsible for presenting changes to model prototypes for DHSS staff to review throughout the design process. The Contractor will be responsible for conducting a walk-through of the Design Document with DHSS to enhance DHSS's understanding and to facilitate the approval process. Application Programming Interfaces (APIs) used to communicate between components and modules or with external systems must also be defined in the DSD document.

Implementation planning has a strong management focus which requires best practice approaches, skills and experience. The Contractor will prepare an implementation plan (Deliverable 3.2, 4.7, 8.1) to execute its implementation strategy for successful deployment of the DMES on schedule, on scope and on budget.

The Contractor must complete the Architecture Review Board (Deliverable 3.4) requirement and DHSS must approve the deliverable documents in order to complete the Design Phase. Portions of the DSD approved by DHSS may be used to satisfy ARB standards and deliverable requirements. The Contractor must also include a preliminary system network architecture draft diagram for each proposed environment in the proposal until architecture diagrams can be finalized.

The Contractor shall prepare a Test Management Plan (Deliverable 3.5) to ensure all requirements are addressed and system modules, system components and system interfaces operate as designed within the DMES SOA framework including:

1. Modules are integrated using the defined technology and follow the prescribed method of governance.
2. Medicaid business rules perform as documented.
3. Business modules perform as described in the design phase.
4. The DMES performs as expected during load and stress testing.
5. A safe environment is available for users to test the system.
6. All tests have been completed, documented and passed by the State, and interfaces comply with the Interface Control Document (ICD).

The Contractor shall prepare a Data Conversion Strategy (Deliverable 3.7) to be delivered as part of the proposal for which its primary purpose is to document and communicate the data conversion scope, objectives, approach, and requirements.

B.1.14.2 DHSS Design Responsibilities

DHSS responsibilities for the Design task are:

1. Provide staff commensurate with the DHSS staffing levels defined in SOW Attachment I – State Responsibilities and DMES Project Team Composition to participate in scheduled meetings and walkthroughs of Contractor Deliverables.
2. Respond to Contractor inquiries related to System requirements and DHSS policies and procedures.
3. Review and approve or provide comments on draft Deliverables.
4. Review and approve Deliverables.
5. Using the Network Upgrade Requirements Deliverable, modify the DHSS network and desktops to meet the requirements.

6. Monitor Contractor performance.

B.1.14.3 Contractor Design Responsibilities

Contractor responsibilities for the Design task are:

1. Prepare Detail System Design document.
2. Prepare the Implementation Plan (versions 1.0).
3. Prepare System Architecture and Design document.
4. Prepare Architectural Review Board documents.
5. Prepare the Test Management Plan.
6. Prepare the Network Upgrade Requirements Deliverable.
7. Prepare the Date Conversion Strategy Document.
8. Prepare and submit Deliverables for approval.

B.1.14.4 Milestones

The critical milestones that affect the schedule or impact progress during the Design task are:

1. Preparation of the DSD document and draft System Architecture and Design document and walk-through with appropriate DHSS staff.
2. DHSS approval of the DSD and System Architecture and Design documents.
3. DHSS approval of the Architectural Review Board documents.
4. Completion and DHSS approval of the Implementation Plan (version 1.0) and the Test Management Plan.
5. Completion and DHSS approval of the Network Upgrade Requirements Deliverable.
6. Completion and DHSS approval of the Data Conversion Strategy document.

B.1.14.5 Deliverables

The Contractor shall meet the requirements for Deliverables presented in Attachment E – Deliverables:

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
3.1	Detailed System Design Version 1	1.9	No	
3.2	Implementation Plan – Version 1	1.10	No	
3.3	System Architecture and Design Documents (SADD) a) Interface Detail Design (IDD) and Integration Specification document b) Interface Control Document (ICD)	1.11	No	

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
3.4	Architectural Review Board	1.12	Yes Conceptual Architectural Diagram Only	
3.5	Test Management Plan	1.13	No	
3.6	Network Upgrade Requirement	1.14	No	
3.7	Data Conversion Strategy	1.15	Yes	

DHSS review of the Services and Deliverables of this task will ensure that:

1. The Detailed Design Documents correlate and accurately reflect business processes and workflows and technical function requirements.
2. The System Architecture and Design addresses the defined functional, performance and security requirements of the system and assures the required data interfaces with other systems.
3. The Architectural Review Board documents are in compliance with DHSS standards and are compatible with the DHSS Enterprise architectural framework.
4. The Systems design is compatible with the DHSS network/computing environment and with the network upgrade requirements, will adequately meet the DMES requirements.
5. The implementation plan is iteratively developed to identify additional risks and issues while executing the defined scope and schedule of the plan through the SDLC.
6. The Testing Plan allows DHSS to track testing of the DMES during construction, and deliverables meet the minimum requirements defined in Attachment E – Deliverables.
7. The data migration strategy used to transfer system data from the legacy MMIS to the new DMES provides a sustainable roadmap yielding complete, accurate, successful results.

B.1.15 Task 4 – Development

This task addresses System development activities related to the new modular DMES that complies with all of the requirements of this RFP. The Contractor shall ensure that development is based on the DHSS-approved Detailed System Design (DSDs) and System Architecture and Design and complies with all current state and federal requirements.

B.1.15.1 Objectives

The major objectives for this task are the development and testing of the new DMES to achieve the functional and technical requirements established during task 2, the Detailed Requirements Analysis and Design Tasks. Development and testing work must be completed according to the DHSS approved Implementation Plan.

B.1.15.2 DHSS Development Responsibilities

DHSS responsibilities for the development task are:

1. Provide staff to participate in scheduled meetings and walk-through of Contractor deliverable presentations commensurate with the DHSS staffing levels defined in Attachment I – State Responsibilities and DMES Project Team Composition.
2. Respond to Contractor inquiries related to system requirements and DHSS policies and procedures.
3. Facilitate the testing processes by providing test data and test files to the Contractor.
4. Assist the Contractor and the State in closing out action items.
5. Review and approve all changes to design deliverables.
6. Review and approve Deliverables.
7. Monitor Contractor performance.

B.1.15.3 Contractor Development Responsibilities

Contractor responsibilities for the Construction task are:

1. Provide the Development Environment that consists of the system hardware, software, networks and workstations to develop and implement the new MMIS.
2. Execute and report on planned development activities.
3. Develop the Test Plan that consists of the plans to conduct unit, system, integration, stress and acceptance testing.
4. Develop DMES documentation including the User's Manual – Version 1 and Operating Procedures – Version 1.
5. Complete Test Plans and conduct testing as planned using an automated system test tool.
6. Support the QA Contractor Independent Verification and Validation process as defined in RFP Attachment D – DMES Systems Operations and Maintenance Tasks.
7. Document test results.
8. Conduct walk-through of Deliverables as needed.
9. Prepare and submit Deliverables for approval.

B.1.15.4 Milestones

The critical milestones that affect the schedule or impact progress during the Construction task are:

1. DHSS acceptance of the development environment.
2. Completion of unit, modular and system component, integrated systems and stress testing.
3. DHSS approval of test plan and Development Test Results.
4. DHSS approval of new and updated systems documentation (e.g., User Manual, Operating Procedures, DSDs) and code library deliverables.
5. Walk-through of draft deliverables.

B.1.15.5 Deliverables

This section defines the Contractor Deliverables related to the Construction Task of the Project. Deliverables noted with an asterisk (*) shall be approved prior to commencement of the Acceptance Testing Task.

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
4.1	Development Environment *	1.16	No	
4.2	Code Library - Version 1: Test Environment *	1.17	No	
4.3	Development Test Results *	1.18	No	
4.4	User Manual – Version 1 *	1.19	No	
4.5	Operating Procedures – Version 1 *	1.20	No	
4.6	Detailed System Design Version 2	1.9	No	
4.7	Implementation Plan – Version 2	1.10	No	

DHSS review of the Services and Deliverables of this task will ensure that:

1. A development environment is established that provides a mature process to support the extension of the proposed Base System to meet DHSS requirements and to support future maintenance and enhancement activities.
2. Planned development activities and methodologies are executed and reported.
3. The DMES is developed while maintaining version control integrity.
4. DMES error identification and closure is tracked and reported.
5. DHSS approves the DMES for transition to the Acceptance Testing and the Training tasks based on an agreement that defines the level of open system errors.
6. Deliverables meet the minimum requirements defined in Attachment E – Deliverables.

B.1.16 Task 5 – Data Conversion

An integral part of the project will be to integrate into the new system, historical data from the following existing DHSS system(s):

- Legacy DMES.
- Legacy POS PBM.

Conversion controls, especially the monitoring and proof of initial conversion results, are very important to ensure that the transactional source data converted into the system is accurate prior to implementation. Initial and ongoing conversion controls and balancing procedures must be described. The Contractor shall make every effort to maintain data integrity and validity as data is converted to support the new DMES. The Contractor will develop a plan that outlines the process to be used to ensure that the entire conversion task results in accurate migration of system data to the new DMES and will execute the plan upon approval from DHSS.

B.1.16.1 Objectives

The conversion process, which precedes the Implementation Task of the Project, must be error free and completed before acceptance testing can proceed. The planning and execution of the conversion activities must be comprehensive and well documented. The new databases must be able to distinguish converted data from new data and all converted data must be date sensitive. Data mapping and conversion modules must be well documented in order to support research of conversion problems uncovered during the implementation and operations tasks

B.1.16.2 DHSS Conversion Responsibilities

DHSS responsibilities for the Data Conversion task are:

1. Provide staff commensurate with the DHSS staffing levels defined in SOW Section 9 to participate in scheduled meetings and walkthroughs of Contractor Deliverables.
2. Respond to Contractor inquiries related to data mapping, System conversion requirements, and DHSS policies and procedures.
3. Assist with resolution of Data Conversion issues.
4. Respond to Contractor inquiries related to MMIS interfaces.
5. Review and approve deliverables.
6. Monitor Contractor performance.

B.1.16.3 Contractor Data Conversion Responsibilities

Contractor responsibilities for the Data Conversion task are:

1. Develop a Data Conversion Plan that defines:
    a. A complete list of data, files, and tables to be converted, including the sources of the data.
    b. A list of default data values and new data requirements as needed.
    c. A data mapping between current systems and the future systems and provide a conversion plan, including a description of how full conversion will be completed and validated.
2. Conduct data conversion according to the Data Conversion Plan.
3. Identify, track, and resolve data anomalies during data conversion.
4. Develop and test conversion programs.
5. Handle all required manual data conversion or data entry activities needed.
6. Prepare conversion test results document.
7. Conduct walkthrough of Deliverables.
8. Obtain DHSS comments on draft Deliverables.
9. Prepare and submit final documents for approval.

B.1.16.4 Milestones

The critical milestones that affect the schedule or impact progress during the Data Conversion task are:

1. DHSS approval of Data Conversion Plan Deliverable.
2. DHSS approval of Data Conversion Testing Results Deliverable.

B.1.16.5 Deliverables

This section defines the Contractor Deliverables for the Data Conversion Task. Deliverables noted with an asterisk (*) shall be approved prior to commencement of Acceptance Testing Tasks. The table below also identifies proposal submission requirements that require preliminary Deliverables as a part of the Bidder's response.

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
5.1	Data Conversion Plan	1.21	No	
5.2	Conversion Test Results *	1.22	No	

DHSS review of the Services and Deliverables of this task will ensure that:

1. The source of data is properly mapped into the new DMES database.
2. Data anomalies are identified and closure is tracked and reported.
3. DHSS approves the System for transition to the Acceptance Testing and Training Task based on an agreement that defines the closure of open data anomalies.
4. The accuracy of data conversion is validated.
5. Deliverables meet the minimum requirements defined in Attachment E – Deliverables.

B.1.17 Task 6 – Acceptance Testing

The Contractor is responsible for facilitating Acceptance Testing of the entire DMES to ensure that the new system meets the functional, technological, and operational requirements of DHSS. DHSS is responsible for participating in Acceptance Testing and for system sign-off and acceptance. DHSS sign-off on Acceptance Testing is a prerequisite to Task 9, Implementation. Acceptance testing will focus on structured system testing, and operations readiness and load testing. Critical deficiencies identified during Acceptance Testing may require the Contractor to conduct rework defined in Tasks 2 through 5 and modification of the associated deliverables before DHSS sign-off of the Acceptance Testing Task and deliverables. Based on the Contractor's phased implementation plan, Acceptance Testing may be conducted in phases. Completion of this task is the first step in DHSS's acceptance of the System.

B.1.17.1 Objectives

The objective of the acceptance testing is to ensure that all requirements and related system functions are complete and accurate. Testing will assure the operations and hardware/software/telecommunications aspects of the new DMES are functioning as designed. Testing will demonstrate that the new DMES is ready to process inputs, pay and adjust claims correctly, meet reporting requirements, utilize the State data communication network, and have a stable back-up and recovery capacity. Testing will include actual claims processing in a full

operational environment from receipt of claims through financial processing, history update, and reporting.

The Contractor must propose a load testing tool and describe the load testing process and results. The new DMES will be tested under maximum operational load conditions and will include production of output files and reports. Claim volume testing and new DMES interface transactions volume testing will also be conducted to demonstrate the systems production capacity. Production and test data will not be co-mingled.

Operational Readiness testing will measure the competency, skill level, and proficiency of the FA Contractor staff and operations during workflow simulations and testing while demonstrating Medicaid business outcomes.

The Contractor shall deliver a testing environment that simulates the production environment including workstations, telecommunications, a security layer, hardware and DMES application software and the use of representative test data. The test environment will utilize separate data files from the production System. The Contractor will schedule and provide access to the test environment for DHSS staff and the Quality Assurance Contractor.

B.1.17.2 Letter Certifying that the DMES Is Ready for UAT

The Contractor must issue a letter to DHSS certifying that: all data, user manuals, testing facilities, and security accesses necessary to perform UAT have been provided and DHSS must approve of the content of the letter. As stated in the Conversion Plan, the data used for UAT will be based on converted data. The DHSS approved letter is the authorization for the Contractor to proceed to the next testing phase.

B.1.17.3 DHSS Acceptance Test Responsibilities

DHSS responsibilities for the Acceptance Test task are:

1. Conduct Acceptance Testing of DMES requirements. DHSS will designate a sign-off authority and provide SME staff for each part of the Acceptance Test checklist and will conduct acceptance testing activities.
2. Document and report testing abnormalities.
3. Review and provide comments on draft deliverables.
4. Review and approve deliverables.
5. Monitor Contractor performance.

B.1.17.4 Contractor Acceptance Test Responsibilities

Contractor responsibilities for the Acceptance Test task are:

1. Establish the Test Environment including implementation of an automated testing and defect/issue tracking tool. Provide an interface with sufficient capacity to allow the State network to provide DHSS access to the Test Environment.
2. Execute testing according to the Test Plan.
3. Facilitate acceptance testing as defined in the Test Plan.
4. Provide training to DHSS staff on the tools and methodology to support this task.
5. Monitor and record testing results.

6. Document problem conditions discovered in testing requiring corrective action and resolution.
7. Correct identified problems, document modifications, and conduct re-testing.
8. Update System, user, and operations documentation and other task deliverables as needed.
9. Prepare and submit draft test results and other deliverables for review.
10. Conduct walk-through of test results deliverables.
11. Submit updated Source Code Library.
12. Submit the Business Continuity Plan for Systems Operations and Maintenance.
13. Prepare and submit final deliverables for approval.

B.1.17.5 Milestones

The critical milestones that affect the schedule or impact progress during the Acceptance Testing task are:

1. DHSS approval of test environment.
2. DHSS approval of test results, including corrective action taken.
3. DHSS approval of updated user, System and operations documents.
4. DHSS approval of Source Code Library for acceptance testing.
5. DHSS approval of the Business Continuity Plan for Systems Operations and Maintenance.
6. DHSS approval of DSD Version 3.
7. DHSS approval of Acceptance Test and Operational Readiness Testing completion. Approval of all Test Results must be complete before proceeding to Task 8, Implementation.

B.1.17.6 Deliverables

This Section defines the Contractor Deliverables related to the Acceptance Testing Task. Deliverables noted with an asterisk (*) shall be approved prior to commencement of Implementation Tasks.

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
6.1	Test Environment*	1.23	No	
6.2	Acceptance Test Plan*	1.24	No	
6.3	Acceptance Test Results*	1.25	No	Contract Start + 20 months
6.4	Operational Readiness Testing Plan*	1.26	No	Contract Start + 20 months
6.5	Operational Readiness Test Results*	1.27	No	Contract Start + 20 months
6.6	Source Code Library - Version 2: Acceptance	1.17	No	Contract Start + 20 months

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
	Testing Environment*			
6.7	Business Continuity Plan for Systems Operations and Maintenance	1.7	No	Contract Start + 20 months
6.8	Detailed System Design Version 3	1.9	No	Contract Start + 20 months

DHSS review of the Services and Deliverables of this task will ensure that:

1. The acceptance test results are sufficient verification that System capabilities fulfill the requirements identified in Attachment C – DMES Functional Requirements.
2. Designated DHSS representatives review and accept assigned DMES requirements.
3. All detected critical errors are adequately addressed and testing is re-accomplished to assure the System meets requirements.
4. The DSD is updated to Version 2 to reflect any System changes that occurred as result of acceptance testing.
5. DHSS approves the System for transition to the Implementation Task based in an agreement that defines open System errors.
6. Deliverables meet the minimum requirements defined in Attachment E – Deliverables.

B.1.18 Task 7 – Training

Training is a critical Contractor responsibility. The Contractor must provide training to all staff using the new DMES including the Provider community. As part of the proposal, the Contractor shall describe its training strategy and include a training plan outline and schedule for DMES users. The strategy and plans prepared in this task shall demonstrate an understanding of DHSS training requirements, the Contractor's role in the training task, and the training-related tasks that are needed to support the Data Conversion (Task 5), Acceptance Testing (Task 6), and Implementation (Task 8) tasks of the Project. A discussion of the methods proposed to develop and deliver training necessary to ensure effective use and reliable operation of the new DMES must be included.

The Contractor will evaluate the effectiveness of the training to support DHSS staff capabilities and will recommend and support improvements during the first year of FA operations.

B.1.18.1 Objectives

The objective of the Training task is to ensure that both DHSS and Contractor staff and DMAP Providers have the appropriate level of knowledge and skill to effectively interface with the DMES and to perform and execute various operating, maintenance and business functions related to job responsibilities.

The Contractor shall develop Training Plans and training support materials, including handouts, instructions or training outlines, classes, presentations and initial login administration to meet the individual knowledge and skill needs for DHSS staff (including contractors and community-based partners). Training and training support materials will be based on approved user and operations manuals as well as procedures manuals developed by the Contractor in previous

tasks. All documentation must be available for use during acceptance testing to verify accuracy, comprehensiveness, understandability, and usability.

DMES training needs to be provided for three identified groups:

1. DHSS Trainers.
2. DMES users training.
    a. DMES users.
    b. Portal Users such as providers.
3. Technical staff that will support the DMES.

DHSS shall assist in the identification of specific individuals to be included in the types of training based on the training strategy defined in the Contractor Training Strategy. Training for each group will encompass the following:

- **DHSS Trainers Group Training.** Prior to conducting User and Provider Training, the Contractor shall provide training to the DHSS Training Group. This training will enable the DHSS Training Group to participate in Enterprise-wide training as needed and eventually assume full responsibility for on-going training beginning the second full year of operations.
- **DMES User Training.** The DMES User Training will include a basic DMES overview that provides a system orientation and basic operation for all DHSS DMES users including Providers. State sites can be used for training as well as Contractor sites. User training is required in each of the three State counties.
- **Technical Staff Training.** Technical training will emphasize the understanding and skills needed to perform assigned duties in support of the new DMES. Technical training shall be provided to all designated DHSS systems staff. Technical training will not include Third Party Software basic training (example: third party database basic programming curriculum).

Login administration will include developing a plan for initially distributing passwords to DHSS users in conjunction with the training process. The Contractor will support login administration until the end of the Implementation Task.

The Contractor is encouraged to use a combination of classroom and distance learning techniques to implement training for DHSS staff and partners. The training requirements include access to a training room provided by the Contractor with the necessary equipment to train state and contractor staff on the operation of the system.

The Contractor must also address methodologies and tools for evaluation of training effectiveness

B.1.18.2 DHSS Training Responsibilities

DHSS responsibilities for the new DMES training task are:

1. Provide access to the list of participating providers for provider training activities.
2. Identify and assign DHSS staff to training. Manage DHSS staff attendance and participation.
3. Assist in locating physical locations for statewide training.
4. Participate in user training sessions.

5. Participate in technical training sessions.
6. Review and approve deliverables.
7. Assume responsibility for login administration after the completion of the Implementation Task.
8. Monitor Contractor performance.

B.1.18.3 Contractor Training Responsibilities

The Contractor responsibilities for the new DMES training task are:

1. Prepare the Training Plan including training schedule (including dates, times, locations, participants).
2. Prepare and establish training environment and training facility. Provide remote training capabilities.
3. Prepare Training Materials.
4. Complete MMIS Login Administration activities.
5. Ensure that DHSS standards for security and training (including the American Disabilities Act) standards are adhered to.
6. Conduct walk-through of deliverables as needed.
7. Conduct training.
8. Prepare and submit the Training Report.

B.1.18.4 Milestones

The critical milestones that affect the schedule or impact progress during the Training task are:

1. DHSS approval of Training Strategy Deliverable.
2. DHSS approval of Training Plan Deliverable.
3. DHSS approval of Training Materials (for each type of training).
4. DHSS approval of the Training Environment.
5. DHSS approval of completion the Training Report.

B.1.18.5 Deliverables

This section defines the contractor deliverables related to the training task deliverables noted with an asterisk (*) shall be approved prior to the acceptance testing, implementation, and certification tasks. The table below also identifies proposal submission requirements that require preliminary deliverables as a part of the Bidder's response.

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
7.1	Training Strategy*	1.28	Yes	Proposal
7.2	Training Plan *	1.29	No	
7.3	Training Environment*	1.30	No	
7.4	Training Materials*	1.31	No	

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
7.5	Training Report*	1.32	No	Contract + 24 months

DHSS review of the services and deliverables of this task will ensure that:

1. Training facilities and remote training capabilities are established well in advance of training events and provide a production like environment.
2. Training and user login administration is accomplished as planned and that training attendee feedback on the quality of the training is rated as level 4 or greater on a 5-level rating system.
3. Training includes coverage of DMES interfaces and reports.
4. Deliverables meet the minimum requirements defined in Attachment E – Deliverables.

B.1.19 Task 8 – Implementation

The Contractor will plan and prepare to for all aspects of the DMES to be at full functionality on the go-live date. Before the start of the Implementation task, all requirements will have been met through successful testing and must satisfy the functional and technological requirements specified in the RFP and as documented during the requirements analysis and systems design activities.

The Contractor will describe its overall approach to implementation, ensuring that the DMES is ready to be implemented and that DHSS approvals have been obtained to begin operations. System, user, and security documentation must be complete. System response time and user and automated interfaces must be clearly assessed and operational.

The Implementation Phase will end upon successful implementation of the DMES and resolution of start-up issues. DHSS acceptance of this task will complete the acceptance of the System. The Contractor will complete this task by Contract Start + 32 months.

B.1.19.1 Objectives

The objectives of the Implementation Task are to install the new DMES and to conduct operational tests of the system in production. The Contractor shall complete implementation activities in such a way that there is no disruption to client and provider services. All functions must work efficiently, in a timely manner, and as designed.

B.1.19.2 DHSS Implementation Responsibilities

DHSS responsibilities for the Implementation Task are:

1. Provide staff commensurate with the DHSS staffing levels defined in Attachment I – State Responsibilities and DMES Project Team Composition to participate in scheduled meetings and walk-throughs of Contractor deliverables.
2. Review and approve or provide comments on draft deliverables submitted by the Contractor.
3. Review and approve final deliverables.
4. Provide approval to implement the new DMES.

5. Implement and support the operation of the new DMES, including providing help desk support (level 1), user login administration, personal computer resource management, and connectivity issues and (level 3) situational, operational or policy interpretation .
6. Implement and support the updated business processes that support the new DMES.
7. Monitor Contractor performance.

B.1.19.3 Contractor Implementation Responsibilities

Contractor responsibilities for the Implementation Task are:

1. Establish the production environment as defined in the Implementation Plan, including software installation, site preparation, and installation schedule.
2. Conduct final data and file conversion activities.
3. Conduct final System interface tests.
4. Update and produce final system documentation including Source Code Library – Version 3, User Manual – Version 2, Operating Procedures Version 2, Implementation Plan – Version 3 and other documentation as needed.
5. Conduct walk-through of deliverables. Obtain DHSS comments on draft deliverables.
6. Provide Help Desk Support (levels 2).
7. Prepare and submit final deliverables for approval.
8. Obtain approval from DHSS to implement the System.
9. Implement the DMES.
10. Ensure the optimal processing of the new DMES, including production monitoring, emergency maintenance, and assistance in computer resource management and data resource management activities during the first 90 calendar days of operation.
11. Monitor System processing and performance to ensure that all functions and features are operating correctly, and correct any errors identified during the initial operations period.

B.1.19.4 Milestones

The critical milestones that affect the schedule or impact progress during the Implementation task are:

1. Documentation demonstrating that the production environment is established.
2. Documentation demonstrating that the final data and file conversion activities have been completed and tested.
3. Documentation demonstrating that the final System interface testing has been completed and documented.
4. Walk-through of final system, user, and operations documentation with DHSS staff.
5. Approval of final documents by DHSS staff.
6. DHSS approval of Final Implementation Plan deliverable.
7. DHSS approval of Source Code Library for Production Environment deliverable.

8. Delivery of the Implementation Certification Letter.
9. DHSS approval to proceed with Implementation.

B.1.19.5 Deliverables

This Section defines the Contractor deliverables related to the new DMES Implementation. Deliverables noted with an asterisk (*) shall be approved prior to production.

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
8.1	Implementation Plan – Version 3*	1.10	No	
8.2	Production Environment *	1.33	No	Contract Start + 29 months
8.3	Source Code Library – Version 3: Production Environment *	1.17	No	Contract Start + 29 months
8.4	User Manual – Version 2	1.19	No	Contract Start + 29 months
8.5	Operating Procedures – Version 2*	1.20	No	Contract Start + 29 months
8.6	System Documentation	1.9	No	Contract Start + 29 months
8.7	Implementation Certification Letter	1.34	No	Contract Start + 29 months

DHSS review of the services and deliverables of this task will ensure that:

1. For the implementation period, the Contractor demonstrates that the DMES meets the performance standards identified in Attachment L, Section L.7.2.
2. All functions and features are operating to meet requirements and are available to all DMES users.
3. The DSD Version 3 is update to reflect any resolution of non critical defects and transition to Final System Documentation.
4. Based on proven operations, the system is accepted by DHSS.
5. Deliverables meet the minimum requirements defined in Attachment E – Deliverables.

B.1.20 Task 9 – Operations – Fiscal Agent Services

This section describes the Contractor's FA responsibilities and performance expectations for business and program functions related to the core DMES, its modules and system components.

This phase will begin on or before July 1, 2016, and end on or around June 30, 2021, or as extended pursuant to the terms and conditions of the Contract. The Contractor will provide on-going FA services for up to 5 base years and 6, 1-year option periods to be exercised by DHSS.

The Contractor must operate the DMES and perform all business functions described in Attachment C – DMES Functional Requirements from the date of implementation of each

component until each business function is turned over to a successor fiscal agent at the end of the Contract, including any optional additional periods or extensions. DHSS will monitor and review Fiscal Agent operations activities for enforcement of Contract provisions, accurate timely processing of fee for service claims, quality of call customer service, and other activities as described in the master SLA (Attachment L – Contract Terms and Conditions). The Contractor will be responsible for executing the operations of the DMES on behalf of the State and will have the authority to process and pay claims and execute other financial management functions of the Delaware Medical Assistance Program (DMAP).

Note: The SOW for POS-PBM operations is discussed in Task 12.

B.1.20.1 Objectives

The objective of this task is to ensure that the Contractor provides the proper level of operational support for all critical business areas to meet or exceed the States performance expectations and performance standards identified in the SOW. In conjunction with ensuring the proper level of support, the Contractor must shows its commitment by providing staff resources that are skilled, experienced, competent and capable of delivering; Client Management Services, Provider Management Services, Transaction Processing (HIPAA standard transactions including; claims and remittance advices), Web Portal Content Management Services and Financial Management Services.

In addition, the Contractor must maintain consistent quality standards. The Contractor will deliver a Quality Management Plan to DHSS 90 days before the scheduled start of operations. The plan must address the Contractors commitment to retaining the personnel skills, and competency levels originally proposed for project operation as well as explain the philosophy and approach to the organizational operating quality culture that together will drive the efficient delivery of all DMES services and meet performance expectations.

B.1.20.2 DHSS Responsibilities

DHSS responsibilities for the Operations Task are:

1. Provide contract and administrative oversight.
2. Negotiate all contract amendments and change to the Contract.
3. Make policies, rules, and establish procedures for all DMAP programs and communicate changes to the Contractor.
4. Oversee the correction of errors and discrepancies resulting in file update processes.
5. Define benefit packages for all state health care programs within the DMES and provide support to assist the Contractor enroll/disenroll clients into a managed care program; and any other health management programs.
6. Determine which individuals are eligible to receive benefits in accordance with assigned eligibility coverage groups, eligibility spans, and special program codes.
7. Approve rules and schedule for automated processes to identify Medicaid clients eligible for Medicare and buy-in, and to properly enroll and pay premiums:
8. Provide monitoring and oversight to provider and recipient call centers operated by the Contractor.
9. Monitor the quality of all key performance metrics and SLAs Performance through the use of reporting systems, audits, reports, sampling, and onsite inspection at any time

10. Approve all provider issuances, billing instructions, handbooks, bulletins, and/or notices developed by the Contractor.
11. Define the content, distribution and schedule for all communications to providers and clients.
12. Define content, format, frequency, and media for all reports.
13. Provide to the Contractor the drug codes, procedure codes, diagnosis codes, and categories of services requiring service authorization.
14. Authorize the collection of third party resource information from outside sources and prepare and initiate agreements with insurance companies, governmental agencies, and other entities for performing data matches between their files and the DMES client file.
15. Establish all policy regarding claims administration.
16. Establish and provide rules governing the adjudication of all claims and encounters.
17. Provide additional Medicaid Quality Control (MQC) and review procedures.
18. Release funds for deposits made to the Delaware Medicaid Disbursement account for funding provider payments.
19. Use reports to account for payments and payment recoveries and to monitor banking activities.
20. Approve design, development, work plans, policies and procedures for all data administration activities.

B.1.20.3 Contractor Responsibilities

Functional requirements for the FA operations Task can be found in Attachment C – DMES Functional Requirements. The support tasks for the Contractor include but are not limited to:

1. Contract Management and administration.
2. Coordinate and lead the implementation of a Quality Assurance Program to measure the overall quality of operations and delivery of services.
3. Process and adjudicate all claims in the HIPAA compliant electronic transaction formats.
4. Supports other HIPAA compliant transactions such as the 834 Roster file and 820 premium payment files necessary for managed care operations.
5. Provide remittance advices.
6. Operate a provider call center and perform provider relations functions including enrollment.
7. Support Provider EHR Provider Incentive Payments.
8. Provide TPL verification and lead processing.
9. Perform eligibility determination and processing for the Delaware Prescription Assistance Program (DPAP).
10. Provide Health Care Program Premium processing for the DHCP and the Medicaid for Workers with Disabilities eligibility group.
11. Provide banking services.
12. Support an ad hoc query environment.

13. Accept batching of pharmacy POS health care claims and claims via the internet from Electronic Claims Management Systems (ECMS).
14. Provide Project Facilities (includes facilities which may or may not include representatives of all business partners, subcontractors and State staff assigned to monitor the new DMES replacement system).
15. Project oversight and management.
16. Management and reporting of all SLAs.
17. Coordinate and perform training for State and Contractor staff as well as Medicaid Providers.

The systems O&M support tasks for the Core Medicaid Enterprise System, Systems Integrator, and POS PBM system are discussed in Task 11; POS PBM FA services are discussed in Task 12.

B.1.20.4 Personnel Requirements

The State regards project staff competencies as a key component and major contributor toward the success operation of the new DMES. Thus, the Contractor will be required to demonstrate its ability to recruit and retain skilled and highly qualified staff and provide adequate staffing during the operation phase of the Contract. When addressing Project Staffing in its proposal the Contractor must describe its plan and commitment for staffing for the duration of this Contract.

The following personnel requirements pertain to the Operations FA services Task. Although, some of these positions may be the same as those positions already identified during the DDI phase, they should not be interpreted as duplicative but rather positions that transition between project phases.

Named Staff

The Contractor will be required to provide the following Named Staff for the Operations FA Services Task. Details for the minimum expertise and responsibilities of these personnel can found in Attachment P – Requirements Checklist.

Named Staff for the Operations Phase include:

1. Project Director.
2. FA Account Manager.
3. Deputy Account Manager.
4. Provider/Client Services Manager.
5. Claims Operations Manager.
6. Quality Assurance Manager.

B.1.20.5 Milestones

The critical milestones that affect the schedule or impact progress during the System Support task are:

1. DHSS approval of the Quality Management Plan (annually, including prior to the start of this phase).

2. DHSS approval of the Fiscal Agent Staffing Requirements Capability Report (annually, including prior to the start of this phase).
3. DHSS approval of Annual Status Report for Operations.
4. Contractor submission of Weekly Project Status Reports for Operations.

B.1.20.6 Deliverables

This Section defines the Contractor deliverables related to Operations of the new DMES Implementation. Deliverables noted with an asterisk (*) shall be approved prior to the scheduled start of Operations.

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
9.1	Operations Quality Management Plan*	1.35	No	Contract Start + 29 mo. and annually thereafter.
9.2	FA Staffing Requirements Capability Report*	1.36	No	Semi - Annual
9.3	Weekly Project Status Report	1.37	No	Weekly
9.4	Annual Status Report	1.38	No	Annual

B.1.21 Task 10 – Certification

The system certification planning process typically starts during the final stages of development. As the effort transitions to the testing phase there is an aggressive effort to gather documents, evidence and artifacts that validate and verify the DMES is operating as designed.

In order to obtain maximum Federal Financial Participation (FFP), the new DMES must meet CMS requirements. Throughout the planned and organized progression of the project, deliverable tasks and review criteria have served as the building blocks for successful system certification. This task completes all activities and assembles documentation necessary to substantiate compliance with CMS requirements and obtain CMS certification.

The Contractor must warrant that the system is operating as designed and all defects as evidenced during implementation have been addressed and are fully remediated to the State's satisfaction before final payment is awarded.

B.1.21.1 Objectives

The objective of this phase is to obtain federal certification for the DMES. DHSS must apply for and receive system certification from CMS, by demonstrating that the system meets all requirements and performance standards, before receiving full federal matching funds. The Contractor will be responsible for ensuring that the new DMES meets the standards for MMIS certification, as specified by CMS, for the design, development, and implementation of the system by the completion of Task 8, Implementation + 3 months.

B.1.21.2 DHSS Certification Responsibilities

DHSS responsibilities for the Certification task are:

1. Notify CMS that the new DMES is ready for certification.
2. Approve the composition of the certification team.

3. Provide DHSS resources to participate in the certification review commensurate with the DHSS staffing levels defined in Attachment I – State Responsibilities and DMES Project Team Composition.
4. Review and provide comments on Contractor draft deliverable including artifacts prepared by the Contractor prepared for the certification review.
5. Review and approve deliverables.
6. DHSS will prepare and submit the Certification Readiness Statement to CMS and will coordinate the CMS Certification Review.
7. Monitor Contractor performance in preparing for certification.

B.1.21.3 Contractor Certification Responsibilities

Contractor responsibilities for the Certification Task are:

1. Ensure that the DMES meets federal certification requirements defined in the most current version of Part 11 of the State Medicaid Manual (SMM). The systems documentation finalized by the Contractor will be used to support the certification process.
2. Participate in certification planning and prepare review materials to demonstrate system compliance with certification criteria.
3. Prior to “go-live,” the Contractor will prepare a CMS readiness checklist to assist DMMA in the “go-live” decision.
4. Capture all appropriate artifacts to support the certification process.
5. Prepare presentation materials for DMMA to review.
6. Provide copies of all system outputs needed to demonstrate full functionality back to the start of operations.
7. Participate, as necessary, during the federal onsite certification review.
8. Assist DHSS in locating material needed to answer review team questions.
9. Provide any additional materials needed to resolve any post-review corrective actions.
10. Retain operations staff to provide post-implementation support during the initial months of operations through certification.
11. Resolve any and all corrective actions needed to finalize federal certification, with DMMA approval.

B.1.21.4 Milestones

The critical milestones that affect the schedule or impact progress during the Certification task are:

1. Walk-through of draft deliverables.
2. DHSS approval of Certification Checklist deliverable.
3. DHSS approval of Certification Review Package deliverable.
4. DHSS notification to CMS that the system is ready for certification review and scheduling of certification review.

5. Successful certification.

B.1.21.5 Deliverables

This Section defines the Contractor Deliverables related to Certification. Deliverables noted with an asterisk (*) shall be approved prior to CMS Certification Review. The table below also identifies proposal submission requirements as described in RFP Section 6 that require preliminary Deliverables as a part of the Bidder's response.

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
10.1	Certification Checklist *	1.39	Yes	Proposal
10.2	Certification Review Package *	1.40	No	Completion of Task 9 + 3 months

DHSS review of the services and deliverables of this task will ensure that:

1. The DMES becomes certified by CMS.
2. Deliverables meet the minimum requirements defined in Attachment E – Deliverables.

B.1.22 Task 11 – Systems Operations and Maintenance Support

This section describes the Contractor's operational support responsibilities and performance expectations for the new DMES.

In conjunction with the Operation Tasks described in Task 9, the Contractor shall also provide on-going operation and maintenance (O&M) support for the new DMES for the same contract period, up to 5 base years and 6, 1-year option periods. The Contractor will be responsible for providing application technical support and maintenance services covering routine maintenance, software modifications, changes, and updates, enhancement and general system maintenance. It can be anticipated that changes to healthcare standards and policies will be made during the lifecycle of the DMES that will require demand for these services.

This task is organized into two subtasks:

1. O&M support of the Core DMES including modules and system components that have historically been Contractor supported including standard DMES functionality for claims, client, provider, managed care coordination, financial services and federal reporting.

2. O&M support of the PBM systems that have historically been Contractor supported including the including the Point of Sale (POS), ePrescribing and Pharmacy Prior Authorization.

Should the Pharmacy POS PBM system be delivered and accepted by DHSS prior to the implementation of the full DMES, the Contractor will be expected to provide O&M support for these DMES components during and after the DDI term of the Contract.

The facilities requirements for Systems O&M support are defined in Section 1.11. The onsite requirements are defined in the Section 1.8.

In addition, the Contractor will be responsible for providing integration services and will be responsible for creating an independent system integrator role. The Systems Integrator will function as the central SOA Enterprise administrator and be responsible for the interconnection between system modules and components and governance enforcement of architecture data and interoperable system standards.

B.1.22.1 Objectives

The objective of this task is to ensure that the Contractor provides the proper level of O&M support service, including meeting the performance standards identified in Attachment L – Contract Terms and Conditions. This includes ensuring that an appropriate level of Contractor staff resources is identified to reliably operate, maintain and enhance the new DMES and PBM modules and system components.

B.1.22.2 DHSS Responsibilities

DHSS Responsibilities for this task include:

1. Oversight of Contractor work and responsibilities.
2. Review and approve or provide comments on draft deliverables. The expected deliverables include:
    a. Annual Systems support plan
    b. Annual staffing requirements capability report
    c. Weekly status report
    d. Annual status report
    e. System documentation updates
3. Review and approve final deliverables.
4. Execute upgrades to DHSS network and desktops.
5. Provide information on changes in state policy and system requirements.
6. Negotiate all Contract amendments and change orders to the Contract.
7. Approve the priority and order of changes related to business requirements or other changes to DHSS business processes identified by the Contractor or DHSS.
8. Evaluate and approve technical and design specifications for modifications.
9. Approve changes to technical and functional documentation.
10. Participate in testing process, including user acceptance testing of modifications.
11. Provide Level 1 and Level 3 Help Desk support. Level 1 provides basic software and/or hardware support to callers, while Level 3 support addresses issues that require situational, operational or policy interpretation and requires DHSS support and SME expertise.
12. Monitor DMES performance standards and Contractor performance.
13. Maintain administration of user access to applications.
14. Participate in the SOA Governance Committee meetings.

B.1.22.3 Contractor Responsibilities

Contractor Responsibilities for this task include the following services to meet the requirements listed in Attachment D – DMES Systems Operations and Maintenance Tasks:

1. Preparation and submission of the Systems Support Plan (Deliverable 11.1), the Staffing Requirements Capability Report (Deliverable 11.2), and the Operations and Maintenance Procedure Manual (Deliverable 11.6).
2. Account/Project management Services, including regular weekly and annual status reports (Deliverables 11.2 and 11.3), and presentation of System status as requested by the MMIS Contracts Manager.
3. Systems Operations and Maintenance Support for all DMES modules and system components (including EVS and Pharmacy POS), as well as ongoing operation of the Development, Training, Testing, and Production Environments.
4. Software modifications, updates, changes and enhancements to DMES modules and system components for new and updated requirements and accordingly, the delivery of System Documentation Updates (Deliverable 11.5). The Contractor must use the configuration plan and software development methodology utilized in Task 1-11, which includes support for updating DMES training materials and other systems documentation.
5. Perform routine system maintenance to correct software errors including all incremental third party hardware and software, and perform associated problem tracking and resolution.
6. Perform general maintenance functions to maintain operation efficiency at the level, standards and conditions the DMES was originally approved.
7. Provide Level 2 Help Desk support services for all modules and system components. Level 2 provides for more system-specific issues that require application expertise or more complex support on hardware and is usually an escalation from Level 1 support.
8. At the request of DHSS, assist in the acquisition and implementation of any necessary hardware, software, or Third Party Services support.
9. Assist with the identification, prioritization and categorization of changes to business requirements as they relate to the functional areas and MECT business processes.
10. Perform ongoing management of SOA integration services which will be responsible for:
    a. Operation and maintenance of the SOA framework and ESB
    b. Developing standards, templates, policies, and procedures
    c. With the assistance of the State, establish the SOA Governance Committee and conduct meetings as specified by the State
    d. Ensuring that all interfaces utilize established standards and advance CMS modularity and interoperability requirement initiatives
    e. Management and administration of all Open and Application Programming Interfaces (APIs)
    f. Maintaining a single sign-on infrastructure
    g. Coordination and implementation of technical and operational requirements for the integration functions
    h. Definition of the Enterprise Information Model and system interfaces
    i. Inventory and maintain documentation of all interfaces via the Interface Control Document (ICD)

j. Developing and maintaining the Service Registry

k. Implementing and managing the Information Technology Infrastructure Library (ITIL)

B.1.22.4 Personnel Requirements

The following personnel requirements pertain to the Systems O&M Support Task. Although some of these positions may be the same as those positions already identified during the DDI phase, they should not be interpreted as duplicative but rather positions that transition between project phases. The Contractor's staffing and procedures will be formulated to distinguish the support of these two subtasks separately. For each subtask, the Contractor shall present the methodology that will be used to determine staffing requirements as well as a proposal for ongoing support. The minimum Contractor Named Staff levels required for this task are defined in RFP Section 5.2.14 and below in the Named Staff Section. Named Staff details regarding the minimum expertise and responsibilities of these personnel can found in Attachment N – Personnel – Minimum Qualifications, Roles, and Responsibilities.

Named Staff

The Contractor will be required to provide the following Named Staff for the Systems O&M and Support Subtasks: the Core DMES modules and system components, and the POS PBM system components:

1. Systems Group Manager.
2. Systems Integration Manager.
3. Systems Administrator.
4. Medicaid Subject Matter Expert.

Other Personnel

DHSS is requiring 25,000 hours of contractor categorized staff time per contract year to apply towards system modification, changes and enhancements to the DMES once the system has been fully implemented. The Contractor will be responsible for full-time staff support comprised of professional systems engineers (programmer/analysts) for all system maintenance change categories. This staff will be in addition to contractor staff performing routine and general system maintenance activities. The Contractor must identify staff to be assigned to system modification, change and enhancement projects. Additionally, the staff can be assigned to support routine and general maintenance activities with the approval of the DHSS.

Other non-programming categorized staff to support routine and general maintenance activities that include: workflow analysis, system testing, documentation updates, and program procedure tasks may consist of architects, testers, business analysts, security experts, DBAs, change management personnel, and/or administrative staff. The mix will be left up to the Contractor, as long as the required level of service is met.

Contractor staff responsibilities for all system maintenance activities shall be prioritized by the DHSS, with input from the Contractor. Within these priorities, the Systems Manager shall be responsible for directing the work of contractor staff to ensure that all maintenance and modification efforts proceed in a timely manner. All module and system component functions shall be covered by at least one contractor systems/programming staff with extensive knowledge and experience in the corresponding technical area. Team members should be sufficiently cross-trained to support temporary changes in priorities and/or responsibilities.

Minimum qualifications for all contractor categorized staff can be found in Attachment N: Personnel – Minimum Qualifications, Roles, and Responsibilities.

B.1.22.5 Milestones

The critical milestones that affect the schedule or impact progress during the System Support task are:

1. DHSS approval of the Systems O&M Support Plan (annually, including prior to the start of this phase).
2. DHSS approval of the Staffing Requirements Capability Report (annually, including prior to the start of this phase).
3. DHSS approval of the O&M Procedures Manual (annually, including prior to the start of this phase).
4. DHSS approval of Annual Status Report
5. Contractor submission of Weekly Project Status Reports.

These milestones will apply to modules and system components (e.g., Pharmacy POS, EVS) delivered and accepted by DHSS prior to the full implementation of the DMES. At that time, these milestones will become applicable for the new DME as a whole.

B.1.22.6 Deliverables

This section defines the Contractor deliverables related to Systems O&M Support of the DMES. The Contractor shall meet the requirements for deliverables presented in Attachment E – Deliverables:

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
11.1	Systems Operation and Maintenance Support Plan	1.41	No	Annual
11.2	Staffing Requirements Capability Report	1.42	No	Semi -Annual
11.3	Weekly Project Status Report	1.37	No	Weekly
11.4	Annual Status Report	1.38	No	Annual
11.5	System Documentation Updates - Requirements Document - System Architecture and Design - Test Plan - Test Report - User Manual - Operating Procedures - Source Code Library - Training Materials	1.45	No	As required

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
	- Workflow Processes			
11.6	Operations and Maintenance Procedure Manual	1.46	No	Start of Task 11 and Annually

B.1.23 Task 12 – Operations - Pharmacy Benefit Management Services

This section describes the Contractor's FA responsibilities and performance expectations for managing and operating the business functions of the Point of Sale (POS) Pharmacy Benefits Management (PBM) system and any component systems.

The Contractor must operate the POS - PBM and perform all business functions described in Attachment C – Functional Requirements from the date of implementation until each business function is turned over to a successor fiscal agent at the end of the Contract, including any optional additional periods or extensions. DHSS will monitor and review POS – PBM operations activities for enforcement of Contract provisions, accurate timely processing of POS claims, quality of call center service, accurate and timely processing of drug rebates and other activities as described in the master SLA (Attachment L – Contract Terms and Conditions).

The core functions of the POS PBM are:

1. Adjudicate POS claims.
2. Drug Utilization Review.
3. Drug Rebate Program.
4. Pharmacy Call Center Services.
5. Interface with and support ePrescribing data exchange.
6.

B.1.23.1 Objectives

The key objective of this task is to ensure that the Contractor is providing cost-effective POS - PBM services.

The Contractor must exhibit strong core staffing competencies and maintain consistent quality standards. The POS – PBM will also participate in the Contractor's Quality Management program and will contribute and deliver a Quality Management Plan to DHSS 90 days before the scheduled start of POS – PBM operations. The Plan will adhere to the same standards as those discussed in Task 9.

B.1.23.2 DHSS Responsibilities

DHSS responsibilities for this task are:

1. Provide policy support for changes to Pharmacy program policy as well as clarification of current policies.
2. Proactively manage and monitor of all activities associated with the Pharmacy program.
3. Provide hearings service for disputed claims.

4. Support the collection of money associated with drug rebates.
5. Monitor Contractor performance.

B.1.23.3 Contractor Responsibilities

Functional requirements for the Pharmacy POS and other PBM System components can be found in Attachment C – DMES Functional Requirements. In general, Contractor responsibilities for this task are as follows:

1. Process and adjudicate all claims in the HIPAA complaint electronic transaction formats including Pharmacy Point of Sale (POS).
2. Provide pharmacy consultant services (DUR and Preferred Drug List (PDL) Prior Authorization functions) including interface with the Pharmacy POS.
3. Provide clinical parameters to the HCPCS and coordination of the relationship between these codes and the NDC.
4. Provide conversion factors for the HCPCS but also for rebates.
5. Support all ePrescribing interfaces.
6. Perform supplemental drug rebate invoicing and reconciliation.
7. Operate a provider/client pharmacy call center and provide:
    a. Licensed pharmacists during all hours of call center operation to respond to pharmacy related questions that require clinical interventions, reconsiderations and consultation and provide physician support for responses to prior authorization request reconsiderations
    b. Weekly and monthly reports on average call wait time, call volume, number of dropped calls, and average return time for message response
    c. Pharmacy call center accessibility, Monday through Friday from 8:00 a.m. to 5:00 p.m. Eastern Time. This includes all regularly scheduled State employee business days.
    d. A Pharmacist dedicated to the State of Delaware.
8. Maintain a drug reference file.

B.1.23.4 Personnel Requirements

The State regards project staff competencies as a key component and major contributor toward the successful formulation of the DMES Procurement project. Thus, the Contractor will be required to demonstrate its ability to recruit and retain skilled and highly qualified staff and provide adequate staffing during the operation phase of the Contract. When addressing Project Staffing in its proposal the Contractor must describe its plan and commitment for staffing for the duration of this Contract.

The following personnel requirements pertain to the Operations FA services Task. Although, some of these positions may be the same as those positions already identified during the DDI phase, they should not be interpreted as duplicative, but rather as positions that transition between project phases.

Named Staff

The Contractor will be required to provide the following Named Staff for the Operations FA Services Task. Details for the minimum expertise and responsibilities of these personnel can found in Attachment N – Personnel – Minimum Qualifications, Roles, and Responsibilities.

1. Pharmacy Manager.

B.1.23.5 Milestones

The critical milestones that affect the schedule or impact progress during this task are:

1. Implementation of Pharmacy POS System.
2. Implementation of drug rebate program.
3. Implementation of the Pro-DUR program.
4. Establishment of ePrescribing Interfaces.
5. Creation of annual reports listed below.

B.1.23.6 Deliverables

The Contractor shall provide FA services to meet the POS PBM requirements identified by DHSS. This section defines the Contractor deliverables related to the Operation of the POS PBM. Deliverables noted with an asterisk (*) shall be approved prior to each annual one-year option. The Contractor shall meet the requirements for deliverables presented in the following exhibits:

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
12.1	Operations Quality Management Plan*	1.35	No	Contract Start + 29 mo. and annually thereafter.
12.2	Staffing Requirements Capability Report*	1.36	No	Semi - Annual
12.3	Weekly Project Status Report	1.37	No	Weekly
12.4	Annual Status Report	1.38	No	Annual

B.1.24 Task 13 – Turnover

This Task will be exercised by DHSS at the end of the Contract period. When DHSS exercises this Task, the Contractor will be required to transfer responsibilities FA and systems O&M support services for the DMES to a successor contractor (designee). The Contractor must cooperate with the successor fiscal agent, other contractors, and DHSS in the planning and transfer of the DMES and operations. The Contractor must dedicate special additional resources to this phase. This task will begin 12 months before the end of the Contract period and end 6 months after the end of the Contract period, or as extended by the exercise of Contract provisions or amendments to the Contract. For planning purposes, this phase should begin on or about July 1, 2020 and end on or about December 31, 2021. This section describes the Tasks necessary to ensure a smooth turnover of the DMES and FA service responsibilities

defined in Attachment B – Tasks .11 and 12 and Attachment D – DMES Systems Operations and Maintenance Tasks

At the beginning of the Turnover Phase, the Contractor must provide DHSS current operational and systematic processing procedures, data, and documentation or other information on a schedule as required by DHSS.

B.1.24.1 Objectives

The Contractor shall provide full support and assistance in turning over the complete and current DMES to a successor contractor. DHSS desires a low-risk turnover that is transparent to recipients, providers, and users. Specific objectives are to provide for an orderly, complete, and controlled transition to the successor contractor and to minimize any disruption of processing and services provided to clients, providers, and operational users of the DMES.

B.1.24.2 DHSS Responsibilities

This section identifies the responsibilities of the State with regard to initiating and facilitating transition tasks in order to transfer or replace the existing DMES.

1. Notify the Contractor of DHSS's intent to transfer or replace the system at least one (1) year prior to the end of the Contract by providing the Contractor with a “Letter of Intent to Turnover” the DMES.
2. Review and approve a turnover plan to facilitate transfer of the DMES to DHSS or to its designated agent.
3. Review and approve a statement of resources, which would be required to take over operation of the DMES.
4. Make DHSS staff or designated agent staff available to be trained in the operation of the DMES, if applicable.
5. Coordinate the transfer of DMES documentation (in hard and soft copy formats), software and data files.
6. Review and approve a turnover results report that documents completion of each step of the turnover plan.
7. Review and accept data from conversion.

DHSS will exercise this task by providing to the Contractor a “Letter of Intent to Exercise” Task 13, before the beginning of the final contract year. The Contractor will respond with a SOW proposal for Task 13 within 15 calendar days. After reviewing and negotiating the Contractor’s SOW proposal for Task 13, DHSS will amend the Contract for the additional tasks identified in the SOW and extend the Contract Term to include the additional 6 months of Post-turnover Services.

DHSS will oversee the DMES turnover activity, ensuring that the incumbent Contractor adheres to the responsibilities and expectations set forth in the approved Turnover Plan (Deliverable 13.1) and that resources identified in the Requirements Statement (Deliverable 13.2) are in place to enable transition activities.

B.1.24.3 Contractor Responsibilities

Contractor responsibilities for Turnover include the following sub tasks:

1. The Contractor will prepare and deliver Turnover Plans 20 business days following the start of Task 13, to DHSS. The Plan must include a Project Schedule/WBS as described in Attachment E – Deliverables, Section 5.1.1 for DMES turnover activities and submit the schedule for DHSS approval.
2. The Contractor shall furnish to DHSS a Resource Requirements Statement, at no extra charge, a complete statement of all resources (personnel, hardware, software and facilities) needed and required by the State or another contractor to take over operation of the DMES, Correct Data Errors: The Contractor shall plan and be responsible for correcting data errors during the conversion process.
3. The Contractor agrees to cooperate with the successor while providing all required turnover services. This will include meeting with the successor and devising work schedules that are agreeable for both DHSS and the successor.
4. On a schedule determined by DHSS, the Contractor must turnover all archived material including the Source Code Library on magnetic tape or a medium approved by DHSS. The Contractor will be required to supply all magnetic tapes or other medium required by DHSS used in the transfer of data, files, and tables and will be responsible for all associated shipping charges.
5. The Contractor shall appoint an appropriately skilled person (subject to DHSS approval) to manage and coordinate all turnover activities. The Contractor shall not reduce operational staffing levels during the turnover period without prior written approval of DHSS.

The Contractor shall also be responsible for, and must correct at no cost, any malfunctions that existed in the System prior to turnover or which were caused by lack of support at turnover, as may be determined by DHSS, for up to 6 months following the turnover of operations.

B.1.24.4 Milestones

The critical milestones that affect the schedule or impact progress during the Transition Task are:

1. DHSS initiates Task 13 with written notice.
2. Turnover Plan and Resource Requirements Statement are submitted and approved by DHSS.
3. Turnover Services are complete and turnover Results Report is submitted and approved by DHSS.
4. Post-turnover Services are completed.

B.1.24.5 Deliverables

This section defines the Contractor Deliverables related to the Turnover Tasks. The Contractor shall meet the requirements for Deliverables presented in Attachment E – Deliverables.

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
13.1	Turnover Plan	1.45	No	Start of Task 13 + 20 days
13.2	Develop a DMES Resource Requirements Statement	1.46	No	Start of Task 13 + 20 days

NUMBER	DELIVERABLE	SECTION	PROPOSAL	DUE DATE
13.3	Systems Documentation and Source Code Library	1.47	No	Start of Task 13 + 90 days
13.4	Turnover Results Report	1.48	No	Turnover date + 1 month

C ATTACHMENT C: DMES FUNCTIONAL REQUIREMENTS

C.1 Delaware's DMES Functional Requirements

The functional requirements apply to and must be adhered to by all Contractors participating in the project as well as those government and private entities, internal and external, who participate in the Delaware Medicaid Enterprise System (DMES) framework. The functional requirements have a strong impact on the relevance of the business and technical processes incorporated into the Delaware enterprise-wide model through and beyond the systems project development phase. The functional requirements articulated in this Section of the document seek to achieve the following objectives:

1. Meet stakeholder needs
2. Align the Information Technology (IT) architecture with the business needs
3. Seamless integration and data sharing
4. Security and dependability
5. Data integrity and consistency
6. Reduce duplication

The Contractor shall adhere to the enterprise-wide technical requirements without exception. The purpose is to establish a shared understanding of DHSS's vision as it relates to; business processes and workflows, user interfaces, application/software architecture, and infrastructure/information architecture throughout the project life cycle. The interrelationships among these architectures and their joint properties are essential to the Delaware enterprise-wide model and are intended to address the important enterprise-wide objectives of this project.

C.2 System Compliance

C.2.1 CMS Certification

DHSS intends to meet all Centers for Medicaid and Medicare Services (CMS) Medicaid Enterprise Certification Toolkit (MECT) requirements. The requirements found in the MECT checklists have been incorporated into the Request for Proposal (RFP) requirements. The DMES must meet all federal requirements for certification as prescribed in the State Medicaid Manual, Part 11 and will be certified.

The CMS Certification requirements and tasks are described in Attachment B – Statement of Work, Task 10 – Certification.

C.2.2 Compliance with Federal Standards

The DMES must comply with the national standards as prescribed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Balanced Budget Act of 1997 and any other federal requirements on or before January 1, 2014 and will be kept in compliance with new and modified requirements.

C.2.3 Requirement to Comply with HIPAA Regulations and Standards

The selected Contractor must certify compliance with HIPAA regulations and requirements related to privacy, security, standard transactions and code sets and the national provider identifier as described in 45 Code of Federal Regulations (CFR) Parts 160, 162 and 164.

The selected Contractor is required to customize/develop the system in accordance with HIPAA requirements, implement the system in accordance with HIPAA requirements and, where the Contractor will operate and maintain the system, operate and maintain the system in compliance with HIPAA requirements.

HIPAA requirements also apply to entities with which State data is shared. If this data is covered by HIPAA, then a Business Associates Agreement (BAA) or contractual agreement specifying Contractor responsibility for protecting and securing this data must be signed by both parties to ensure that this data is adequately secured according to State and DHSS policies and standards (See Section 4.4 for more information on this requirement). This agreement/contract must be in force prior to testing or production implementation of this data exchange.

In its proposal, the bidder will explain their understanding of the HIPAA regulations and their impact on this project particularly in the area of security.

The Security & Privacy functional area identifies the requirements necessary to protect the confidentiality and integrity of electronic Protected Health Information (ePHI) provide controlled access to system and data, monitor system activity, and support HIPAA privacy regulations.

The Security and Privacy business objectives are:

1. Control access to system and data
2. Protect the confidentiality and integrity of ePHI
3. Monitor system activity and act on security incidents
4. Support individual rights specified in the HIPAA Privacy regulations

Security and Privacy – Technical Requirements	
SPT1	Perform data mapping to identify the Protected Health Information (PHI) contained in the system and electronically transfer in order to perform HIPAA business functions.
SPT2	Perform a HIPAA risk analysis and develop a strategic plan to eliminate or reduce HIPAA risks. Analysis must be performed on an annual basis or at the request of DHSS.
SPT3	Develop policies and procedures identifying security measures taken to protect PHI.
SPT4	Implement audit trails to monitor PHI received or forwarded; identify format, access, and purpose for use and test against policies.
SPT5	Review Business Partner Agreements and Chain of Trust Partner Agreements with existing contracts for HIPAA compliance. Reviews will be performed on request or at least annually on a schedule determined by DHSS. The Contractor must provide a plan to DHSS outlining procedures for conducting reviews of contract agreements.
SPT7	Verifies identity of all users, denies access to invalid users. For example: a. Requires unique logon (ID and password) b. Requires authentication of the receiving entity prior to a system-initiated session, such as transmitting responses to eligibility inquiries
SPT8	Provide a single sign-on, including password, for all enterprise modules.

Security and Privacy – Technical Requirements	
SPT9	Provide security access that: a. Allows only authorized inquiry access to designated personnel through an implemented security system as approved by DHSS b. Update capabilities shall be allowed to designated personnel. Security must be imposed at various levels, as deemed necessary by the DHSS (i.e., operator, screen, or data element) c. Audit trail reports shall be produced for all batch and online update transactions as required by DHSS
SPT10	Allow one logon ID per user. Exceptions may be requested by the DHSS.
SPT11	Provide the ability to recover the User ID and password via a secure automated method.
SPT12	Interface with external security access applications.
SPT13	Maintain password policies for length, character requirements, and updates, as defined by the DHSS.
SPT14	Supports a user security profile that controls user access rights to data categories and system functions.
SPT15	Provide the ability to assign online role-based access.
SPT16	Permits supervisors or other designated officials to set and modify user security access profile.
SPT17	Includes procedures for accessing necessary ePHI in the event of an emergency; continue protection of ePHI during emergency operations.
SPT18	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.
SPT10	Provide automatic logoff of a user if a key is not depressed within the time established by the DHSS system policies.
SPT20	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.
SPT21	Alerts appropriate staff authorities of potential violations of privacy safeguards, such as inappropriate access to confidential information.
SPT22	Ensure that the system facilitates auditing of individual claims. Adequate audit trails must be provided throughout the system and the conversion programs. Where override codes are permitted, the use of such codes must be reported. Changes to prices, provider data, and beneficiary eligibility must each be highly controlled and reported and must create appropriate audit trails and reports.
SPT23	Provide secure transmission of batch and all other online claims in compliance with Delaware IT Security Policy.
SPT24	Establish a limit of unsuccessful attempts to access the DE Medicaid Enterprise after which the user shall be disconnected. The system shall disconnect any user for whom a limit has been reached.
SPT25	Contains a data definition for the Designated Record Set (DRS) that allows it to be included in responses to inquires and report requests.
SPT26	Supports data integrity through system controls for software program changes and promotion to production.
SPT27	Provide secure and confidential data requirements for data exchanges.

Security and Privacy – Technical Requirements	
SPT28	Contains verification mechanisms that are capable of authenticating authority (as well as identify) for the use or disclosure requested. For example: a. Denies general practitioner inquiry for recipient eligibility for mental health services b. Permits inquiries on claim status only for claims submitted by the inquiring provider
SPT29	Produce DHSS-defined reports that show who has access to what information for audit purposes.
SPT30	Generate reports related to the claims medical history on the web portal, specifying the user who accessed, what beneficiary was queried upon, and what claims were queried.
SPT31	Support verification mechanisms across applications and platforms.
SPT32	Supports encryption and decryption of stored ePHI or an equivalent alternative protection mechanism.
SPT33	Supports encryption of ePHI that is being transmitted, as appropriate.
SPT34	Supports integrity controls to guarantee that transmitted ePHI is not improperly modified without detection (e.g., provide secure claims transmission).
SPT35	Provides data integrity of ePHI by preventing and detecting improper alteration or destruction (e.g., double keying, message authentication, digital signature, check sums etc).
SPT36	Provides the capability that all system activity can be traced to a specific user.
SPT37	Generates alerts for conditions that violate security rules, for example: a. Attempts to access unauthorized data and system functions b. Logon attempts that exceed the maximum allowed c. Termination of authorized sessions after a specified time of no activity
SPT38	Logs and examines system activity in accordance with audit policies and procedures adopted by the Medicaid agency.
SPT39	Provides security incident reporting and mitigation mechanisms, such as: a. Generate warning or report on system activity based on security parameters b. Terminate access and/or generate report when potential security violation detected c. Preserve and report specified audit data when potential security violation detected
SPT40	Provide online inquiry and report(s) that include all of the current and historical information, in accordance with DHSS policy, about access and rights provided to DHSS and Contractor staff. The report(s) should be standardized as to the data it will contain, but allow user input of run criteria such as ID #, access, timeframes, etc. The inquiry and report(s) must be able to be produced by authorized DHSS and/or Contractor staff at any point in time.
SPT41	Supports procedures for guarding, monitoring, and detecting malicious software (e.g., viruses, worms, malicious code, etc.).
SPT42	Has the capability to respond to an authorized request to provide a report containing the DRS for a given individual.
SPR43	Contains indicators that can be set to restrict distribution of ePHI in situations where it would normally be distributed.
SPT44	Tracks disclosures of ePHI; provides authorized users access to and reports on the disclosures.
SPT45	Meet all federal regulations regarding standards for privacy, security, and individually identifiable health information, as identified in the HIPAA and other federal laws.
SPT46	Has the capability to identify and note amendments to the DRS for a given individual.

Security and Privacy – Technical Requirements	
SPT47	The Contractor must have a secure building meeting all HIPAA Privacy and Security requirements.
SPT48	All Contractor and State staff must wear identification badges at all times.
SPT49	All contractor facilities handling Delaware Medicaid Enterprise data and functions must be performed at secure facilities that meet the HIPAA privacy and security standards.
SPT50	Provides an indicator to suppress generation of documents containing client identification for confidential services or other reasons.
SPT51	Provide the capability to produce HIPAA Certificates of Creditable Coverage on a scheduled and ad hoc basis.
SPT52	Provide the capability to produce HIPAA Privacy Notices on a scheduled and ad hoc basis.
SPT53	Track disclosure of PHI and have the capability to indicate persons authorized to discuss PHI for a client.
SPT54	Complies with provisions for Administrative Simplification under HIPAA to ensure the confidentiality, integrity, and availability of ePHI: a. Provides safeguards as described in the October 22, 1998 State Medicaid Director letter, Collaborations for Data Sharing between State Medicaid and Health Agencies b. Performs regular audits c. Supports incident reporting
SPT55	Complies with provisions for Administrative Simplification under HIPAA to ensure the confidentiality, integrity, and availability of ePHI in transit and at rest.
SPT56	Restrict access to confidential client information.

C.2.4 Requirement to Comply with State Policies and Standards

All proposed solutions submitted in response to this RFP must be fully compatible with the DHSS's technical environment.

Bidder solutions must fully comply with these requirements.

Requirements to Comply with State Policies and Standards	
Ref #	**Requirement**
SSB1	Comply with Master Client Index (MCI) requirements for all systems identifying DHSS clients.
SSB2	Comply with the Integrated Authorization System (IAS) required mechanism for tracking authorized systems users.
SSB3	The State Systems Architecture Standard contains information confidential to the State and is not available from the internet. However, DTI has set up an email address which will automatically send a response with this document attached. The email address is sysarch@lists.state.de.us
SSB4	All contractor staff working on this project will be subject to a Criminal Background Check (CBC). The contractor will be solely responsible for the cost of the CBC. DHSS will review the CBC results. DHSS, at their sole discretion, may request that a contractor staff member be replaced if their CBC result is unsatisfactory. See Attachment L – Contract Terms and Conditions, Section 6 for instructions on this process.
SSB5	Appropriate Contractor staff will be required to fill out DTI's Acceptable Use Policy, Biggs Data Center User Authorization Form, and the Biggs Data Center Non-Disclosure Agreement for necessary authorizations before starting work. Staff working at a secured State site will be issued a security access card by DHSS as per the State Standard.

Requirements to Comply with State Policies and Standards	
Ref #	**Requirement**
SSB6	All components of the proposed DMES, including third party software and hardware, are required to adhere to the policies and standards described above, as modified from time to time during the term of the contract resulting from this RFP, including any links or documents found at the above referenced websites. Any proposed exceptions must be addressed in the Transmittal Letter (Tab 2) of your Technical Proposal**.** See Section 5.2.2, item 2 for more information,

C.2.5 CMS Enhanced Funding Requirements

CMS is encouraging states to broaden their vision in implementing a "big picture" approach to improving the operation of their Medicaid Programs. These changes should occur at the "enterprise" level and prioritize global population health and financial goals while improving the coordination and delivery of care to each Medicaid beneficiary, with an emphasis on those who have the greatest health needs and highest costs.

On April 2011, CMS issued the "Enhanced Funding Requirements: Seven Conditions and Standards" Medicaid Information Technology (IT) Supplement (MITS-11-01-v1.0). The requirements outlined in the CMS Seven Conditions and Standards must not only be met for future Medicaid Management Information System (MMIS) procurements but, in order for States to qualify for enhanced funding. Delaware fully expects that the new DMES will qualify for the full federal enhanced funding match.

The goal is to promote a cost-effective, competitive environment for re-useable MMIS products that can sustain the growing demand for flexible, open, Service Oriented Architecture (SOA) systems in the Medicaid MMIS marketplace environment. DHSS intends to procure a solution that meets the enhanced funding requirements. Bidders need to describe how their solution addresses the Enhanced Funding Requirements.

C.3 General System Requirements

C.3.1 System Design Documentation

The Contractor is responsible for providing to the DHSS complete, accurate, and timely documentation that is accurate and fully describes the design and functionality of all modules and system components in the DMES. The Contractor must prepare updates to the system documentation to incorporate any modifications that have resulted from the completion of UAT. All updates to system documentation must be clearly identified and version history maintained.

The Contractor must provide one copy according to the schedule identified in the Attachment B – Statement of Work. In addition to the hard copy, all system documentation must be maintained online, with access by DHSS authorized personnel. For changes during operations, one updated copy of the documentation must be prepared to reflect any modifications, corrections, or enhancements to the system according to the requirements described in the SOW. All updates to system documentation must be clearly identified and version history maintained. The System Documentation must meet the following requirements:

System Documentation Requirements	
Ref #	**Requirement**
GBB001	Contain facsimiles or reproductions of all reports generated by the modules

System Documentation Requirements	
Ref #	**Requirement**
GBB002	Present Instructions for requesting reports with samples of input documents and/or screens
GBB003	Include narrative descriptions of each of the reports and an explanation of their use must be presented
GBB004	Definition of all fields in reports, including a detailed explanation of all report item calculations
GBB005	Produce Desk Level Procedures for all departments and processes

C.3.2 Database Design

The Contractor will need to take into consideration the design of existing table structures and whether they may carry forward into the solution being proposed or may have to be re-engineered. Quality of the current data needs to be reviewed. Consideration will need to be given to ETL (Extraction, Transformation and Loading) processes for conversion as well as archiving, backups and disaster recovery. The Contractor will be required to provide a data model in Microsoft Visio format.

Database Design Requirements	
Ref #	**Requirement**
GTT002	Comply with Delaware Department of Technology and Information Data Management Policy (PL-GAS-01) by submitting required data models

C.3.3 Data Quality Control

The Contractor must apply professional principles of data management, data security, data integrity, and data quality control. At a minimum, the DMES must provide the following methods and tools for maintaining data quality control:

Data Quality Control Requirements	
Ref #	**Requirement**
GTT003 GTT132	A modern relational database management system must be used.
GTT004 GTT133	All tables must be properly normalized or de-normalized for efficient operation
GTT005 GTT134	Relations between tables within databases must be properly set and controlled
GTT006 GTT135	Database integrity features (such as primary keys, foreign keys, unique constraints) must be used to enforce field and relationship requirements.
GTT007 GTT136	Controls must be in place to prevent duplicate or orphan records.
GTT008 GTT137	Transactions must provide for error recovery (i.e., if the entire transaction does not process completely, the entire transaction is rolled back).
GTT009 GTT138	Communications routines must use checksums or other tools to assure accuracy of a file before it is processed.
GTT010	HIPAA transaction processing must be tested and validated according to guidelines developed by the Workgroup for Electronic Data Interchange (WEDI) Strategic National

Data Quality Control Requirements	
Ref #	**Requirement**
GTT139	Implementation Process (SNIP). (Note: Implementation Guides are now referred to as Technical Reports Type 3 (TR3s) by X12.)
GTT011 GTT140	Test for EDI syntax integrity.
GTT012 GTT141	Test for adherence to national implementation guides (now TR3s).
GTT013 GTT142	Test for balancing.
GTT014 GTT143	Test for inter-segment situations in the implementation guides (now TR3s).
GTT015 GTT144	Test for external code set conformance.
GTT016 GTT145	Test for each specialty, line of business, or provider class.
GTT017 GTT146	Test for implementation guide (TR3) specific trading partners, such as Medicaid.

C.3.4 General System Reporting Capabilities

To the extent possible, reporting should utilize an extract of the production database so as not to adversely affect the performance and response time of the production application. This is critically important for systems that permit ad hoc reporting or user-constructed queries. The State encourages the use of a separate reporting environment especially for complex systems or systems with a large concurrent user base. If a separate reporting environment is being proposed, bidders will include a corresponding system architecture diagram in their proposal.

Bidders will address the following reporting requirements in detail and how their proposed solution meets these requirements. Bidders may include sample report pages as appropriate. Bidders may also discuss how their solution exceeds these requirements with additional included reports or reporting capabilities.

Reporting Requirements	
Ref #	**Requirement**
GTT018	Produce required reports in electronic and paper format, as well as allowing online viewing of the reports.
GTT019	Provide management reporting to DHSS for all aspects of the Delaware Medicaid Enterprise; assist DHSS in definition and design of reports
GTT020	Update and maintain all data elements as required by the federal MMIS General Systems Design and such additional elements as may be necessary for DHSS to meet all federal data set requirements for federal reporting and certification.
GTT021	Ensure all reporting is run on time, is correct, and is delivered according to the requirements of this Contract.
GTT022	Perform data extracts for DHSS affiliates and deliver files as specified by DHSS.
GTT023	Produce ad hoc reports as requested by DHSS.

Reporting Requirements	
Ref #	**Requirement**
GTT024	Produce and assist DHSS in definition and design of general system performance reports.
GTT025	Operate the production report component of the Delaware Medicaid Enterprise, including improvements/enhancements as they are implemented.
GTT026	Maintain necessary data and provide all required reports relative to Delaware Medicaid enrollees, providers and claim activity.
GTT027	Support the production of all required reports on the media specified by DHSS.
GTT028	Produce a Report of required and available Reports to DHSS to include a description of each report, its purpose, and who uses it.
GTT029	Provide all current and future federally required reporting and all DHSS required reporting; included shall be accurate reports that support the management of Medicaid Enterprise.
GTT030	Ensure that all reports, including financial and claims processing reports, cross-check and balance to other Medicaid Enterprise reports and agencies or divisions of the state using the same data.
GTT031	Provide a complete audit trail for management reporting processing. Provide reports and procedures for balancing reports internally (within the subsystem) and with related data from other subsystems.
GTT032	Balance management report data to comparable data from other management reports for data reconciliation.
GTT033	Provide control totals and balancing information for all reports; included shall be the capability for compiling subtotals, totals, averages, variances, and percents of items and dollars on all reports, as appropriate.
GTT034	Provide capability to query on any one element in the database as well as multi-data elements in the database to generate standard queries of summary and detail statistics by variables as defined by DHSS.
GTT035	Submit reports of system errors and failures within one business day of the occurrence.
GTT036	Report weekly to DHSS managers and directors all systems changes that have been implemented.
GTT037	Ensure all reports are produced with 100% accuracy and consistency.
GTT038	Produce Management Accounting and Reporting (MAR) Reports as required.
GTT039	Produce SUR Reports as required.
GTT040	Support the generation of information for all federal reports and supporting data required by CMS, including, but not limited to: CMS-21 Quarterly Report CMS-37 Quarterly Report CMS-64 Expenditures Report CMS-416 EPSDT Report CMS-2082 MSIS Annual Report with quarterly updates
GTT041	Produce reports to allow management to monitor and compare program expenditures and budgeted amounts periodically, including, but not limited to, comparison of actual and budgeted funds, projections of revenue, and calculation of budget variances.
GTT042	Produce reports to support financial planning and policy development, such as comparisons of past, current, and future financial trends.

Reporting Requirements	
Ref #	**Requirement**
GTT043	Produce reports showing managed care-related expenditure information to allow management to generate financial reports on the per capita payments made to managed care entities.
GTT044	Provide Medicare participation information on the level of medical assistance program expenditures for enrollees who also have Medicare coverage
GTT045	Provide information showing enrollee participation and utilization of services indicating both payments and number of enrollees by aid category.
GTT046	Provide information showing the geographic distribution of expenditures and enrollee participation at the county or other level to enable program management to monitor the statewide availability, comparability, and use of services.
GTT047	Provide information to support institutional and managed care payment fee setting.
GTT048	Generate, submit, and correct, if necessary, Medicaid Statistical Information System (MSIS) files and/or cartridges for CMS, according to CMS time frames and as defined by DHSS.
GTT049	Document reasons for CMS-identified errors on MSIS file validation, and implement changes approved by DHSS to reduce the number of errors.
GTT050	Daily reports shall be available by noon of the next business day.
GTT051	Weekly reports and cycle processing reports shall be available by no later than noon of the next calendar day after the scheduled run.
GTT052	Monthly reports shall be available by no later than noon of the 3rd calendar day following the end of the last financial cycle week within the month.
GTT053	Quarterly reports shall be available by no later than noon of the 3rd calendar day following the end of the last financial cycle week within the quarter.
GTT054	Annual reports shall be available by no later than noon of the 20th business day following the end of the year (federal fiscal, State fiscal, or other annual cycle).
GTT055	The system shall display ad hoc and on-demand reports within the timeframes defined by DHSS in the report request.
GTT056	Deliver ad hoc reports as defined during design sessions with the State.

C.3.5 Architecture Requirements

The Contractor must provide a total solution that: meets the requirements of the Delaware Medicaid Enterprise, meets all CMS certification requirements, is aligned with the MITA standards, and meets all Delaware technical and business requirements specified in this RFP. At a minimum, all systems must meet the following architectural requirements:

Architectural Requirements	
Ref #	**Requirement**
GTT057	The bidder must adhere to State of Delaware Enterprise Standards and Policies when securing and protecting data
GTT058	Architecture diagrams and standards for completion as identified in RFP section E.1.12 Deliverable – 3.4 Architectural Review Board Requirements must be maintained throughout the life of the contract and periodically reviewed for compliance
GTT059	The components of the DMES shall be operated using a with web browser based front-end for a common user interface.

Architectural Requirements	
Ref #	**Requirement**
GTT060	Implement a web portal with single sign-on authentication capability so that a client/provider may seamlessly access relevant information stored in other state enterprise systems.
GTT061	Create and maintain architectural components to permit interaction and continuity between all of a client's accounts and benefit information. The State seeks to achieve a "one stop shop" for clients to access their information, accounts or benefits; such as public health care programs, certifying agencies, SSA, nutritional programs, and other programs determined by the State.
GTT062	Utilize web-based solution that is browser independent and supports the State's approved web browsers
GTT063	Provide easy navigation, to include, but not be limited to, the following: a. Drop-down menus b. Application-specific toolbars c. Auto population of persistent data d. Direct links to help functions (e.g., reference information, manuals, and documentation) e. Short-cut and function key functionality f. Navigation menus, fields, and page tabs g. Auto skips from field to field so that the cursor moves automatically to the next field as soon as the last character in the previous field is completely filled h. Cut and paste functionality i. "Forward" and "Back" navigation
GTT064	The ability to access multiple windows by clicking key fields without having to cut and paste data to move from one screens window to another. (e.g., ICN number to claim details, NPI number to enrollment status/taxonomy affiliation, MCI number to eligibility segments, MCO affiliation to effective dates)
GTT065	Provide a single point of sign-on for all activities within the DMES and ancillary components including but not limited to Customer Relationship Management software, rules engine, workflow software, web portal, testing tools, electronic document management system, and reporting repository. Entry to the DMES web portal must support single sign-on from an outside secure web portal.
GTT066	The EDMS image retrieval time stored in the most recent 12 months must be displayed within 10 seconds for 95% of the requests. Each subsequent page of the same document (or a claim and its attachments) must be displayed in 1 second or less 95% of the time. The image retrieval time is the time elapsed after the retrieve command is entered until the image data appears or loads to completion on the monitor.
GTT067	Provide search capability based on wild cards or any combination of fields. For web portals, provide site-wide search capabilities for all documents within the web portal.
GTT068	Provide field level and role-based security that allows only authorized users to see the information necessary to perform their job efficiently. Role-based security must also be available that allows a level of security to be applied to a specific job category.
GTT069	Provide searchable screens that are applicable to specific business areas, including, but not limited to: client, provider, benefits, reference data, claims processing, prior authorization, third party liability (TPL), and financial management.
GTT070	Provide secure access by individual or group level for Contractor staff, DHSS staff, and other designated users approved by the DHSS.
GTT071	Provide browser-based web capabilities for all authorized users, including providers and clients, by configurable search criteria.
GTT072	Provide system availability 24x7, other than for scheduled maintenance. The system will be available 99.8% of the time on a 24x7 basis, except for scheduled down-time as agreed to by DHSS.

Architectural Requirements	
Ref #	**Requirement**
GTT073	Employ best-of-breed tools and support open architecture software that is flexible and cost-effective to modify and maintain.
GTT074	Provide the ability to seamlessly integrate with installed modules, including COTS product components, through a single user sign-on interface.
GTT075	Install software updates and releases to the most recent version for all COTS products within six months of release or based upon DHSS approved schedule.
GTT076	Provide Enterprise Application Integration (EAI), to include web services technology and standards to promote Delaware Medicaid Enterprise applications integration, including an Enterprise Service Bus (ESB) for interfaces.
GTT077	Provide regression testing and expanded system capacity for software version update(s) of COTS products, at no additional cost to the DHSS.
GTT078	Ensure International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) procedure codes, Health Level Seven (HL7) Reference Information Model (RIM) and/or Logical Observation Identifiers Names and Codes (LOINC) functionality,
GTT079	Provide an online audit trail for each transaction, identifying who made the change, what change was made, date/time the change was made, why the change was made and provide a record of the data prior to the time the change was made.
GTT080	Provide functionality to interface with multiple entities outside of the Delaware Medicaid Enterprise for exchange of information, such as; other eligibility determination systems, prior authorization entities, child support enforcement, federal provider exclusion sites, immunization registries, and death registries.
GTT081	Provide one-click access to online context-sensitive Help screens and resources. The Help menu will be accessible throughout the system, windows, tabs, and frames, and will include at the following components: General Screen information, User Manuals link, Data Element Dictionary, and other Division defined resources.
GTT082	Provide metadata management that is accessible by the DHSS staff. Metadata management refers to the activities associated with ensuring that metadata is created/captured at the point of file creation and that the broadest possible portfolio of meta-information is collected, stored in a repository for use by multiple applications, and controlled to remove inconsistencies and redundancies. Within the context of storage management, metadata provides the linkage between the business need or policy and the information or infrastructure (object). The effective management of metadata is therefore critical to information lifecycle management.
GTT083	Utilize open interfaces and exposed application programming interfaces (APIs) to promote integration throughout all Delaware Medicaid Enterprise business processes and sub-processes.
GTT084	Provide the functionality to display all data elements contained on each data record.
GTT085	Provide a “Screen Print” function button that will create a user friendly formatted print of screens applicable to their specific business area (e.g., beneficiary, provider, benefits, reference data, claim types, prior authorization, TPL, and financial management). The layout for these formatted prints will be determined during the DDI Phase, subject to approval by the DHSS.

C.3.6 Delaware MITA Objectives

DHSS supports the Medicaid Information Technology Architecture (MITA) principles associated with high-quality secured software systems (e.g., scalability, adaptability, availability, manageability, and interoperability) as the basis for the system architecture. DHSS intends to acquire a solution that is aligned with MITA and has the capability, corporate planning, support,

and vision to achieve successive MITA maturity levels. DHSS adheres to the MITA roadmap for controlled and strategic transformation.

DHSS has conducted a MITA State Self-Assessment (SS-A), the results of which can be made available, upon request, to those entities submitting a Letter of Interest. DHSS' goal is to work towards a Medicaid enterprise solution that meets the requirements of the RFP and includes MITA maturity level (MML) 3 standards, such as SOA using an ESB infrastructure.

MITA enabling guidelines, processes, and tools provide a framework for the continuous improvement of service delivery and business processes based on efficient technology utilization. MITA depicts this evolution as a progression of maturity levels that reflect the Division's ability to execute business functions in the rapidly changing health care environment. DHSS will use MITA as a tool to assist in the strategic application of technology and enhancements that provide value and contribute to a continuous improvement in the Medicaid program's maturity.

An MML 3 requires that the business process be implemented as a set of reusable business services using the MITA-defined interfaces. The Bidder will maintain a crosswalk of the specific enabling technology or architecture that allows a business process to meet a MML 3 capability so that the State may be able to understand and trace the improvements back to the original MITA 2.01 framework business process. The selected Contractor is expected to assist DHSS in transitioning the significant majority of its MITA business processes to a MML capability of 3 or greater over the SDLC. The business processes not proposed at MML 3 will be improved utilizing the Change Management process.

Note: If MITA has not defined the interface standard for the selected business process, the Contractor in coordination with the Integrator will develop the interface solution and submit it to the SOA Governance Board for adoption. The SOA Governance Board will be comprised of key enterprise stakeholders, Contractor and subcontractor senior managers, and state senior management staff. The group will meet on scheduled intervals to be determined by the board to facilitate change management, and review action items, issues, and risks associated with achieving the goals and objectives of the full project life cycle. Its purpose and objective will be to:

1. Follow the agreed recommendations and plans made through future MITA transition planning activities
2. Set "rules" and manage standards for privacy of data relative to data sharing in conjunction with law and patient rights
3. Define requirements for periodic review of all types of standards (data, policy, procedure, etc.) for applicability, effectiveness, and currency with industry best practices
4. Establish a standard data model to be used across the enterprise

All interfaces must be defined using the MITA/HL7 methodology. DHSS is requiring the Contractor to identify their proposed systems' alignment with MITA and their corporate vision for addressing MITA requirements.

The proposed solution must be business-process focused. It must separate the service layer from the application layer using; processes, business rules, data and metadata management and service management to facilitate modularity and enhanced enhances interoperability across service components and with external applications and data sources.

The Contractor must select or develop flexible tools that are proven in their class, can be purchased or licensed for use beyond the term of this Contract, and can be used by other states. DHSS encourages use of COTS products, when practical, which must meet the needs of the business function, and encourages use of best-in-class subcontracts when other Contractors may offer superior experience and solutions. The Contractor must identify the tools to be used in the proposal and include information on the quality of the tools. DHSS expects the Contractor to take advantage of recent technological advancements and replace the current MMIS with a system that meets all the automation and interfacing requirements presented in this RFP and using SOA principles. It is important that the Contractor present the best solution to satisfy all the technical and business requirements and to provide a solution that will be usable for the Delaware Medicaid Program well into the future.

General MITA Requirements	
Ref #	**Requirement**
GTT086	The Contractor is expected to identify any business processes that are at Level 1 or Level 2 and propose a solution to progressively move to Level 3 or higher

The new MITA 3.0 reflects the use of newer technologies such as cloud computing and recent policies described in the CMS publication Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 2.0 and the Enhanced Funding Requirements: Seven Conditions and Standards, Medicaid IT Supplement, (MITS-11-01-v1.0). All states will be required to prepare an update of their State Self-Assessments within twelve months of release of MITA 3.0; however, the time period for preparing the State Self-Assessment will not begin until CMS has released the member eligibility and enrollment business processes or capability matrices.

C.3.7 Service Oriented Architecture

The Contractor must employ a Service Oriented Architecture (SOA) to take advantage of COTS products and allow for the reuse of system components across business functions as services. SOA is an approach to loosely coupled, protocol independent, standards-based distributed computing where software resources expose their functionality as services and are available on the network. SOA requires the use of business services in addition to technical services. The business services will support business functions within the DMES, and map to all applicable MITA business processes within the MITA Business Process Model, unless they are Delaware specific business processes. Each business service must meet the MITA definition of a business service. The SOA must also enable the agency business units to build business applications quickly and efficiently in the future, by reusing resident SOA infrastructure and service management methodology.

The SOA should feature:

Service Oriented Architecture (SOA) Requirements	
Ref #	**Requirement**
GTT087	Technology Independence: The service components must be able to be invoked from multiple platforms and utilize standard protocols.
GTT088	Standards-Based Interoperability: The system must be able to support multiple industry standards, including, at a minimum: a. HL7 (V3) b. Extensible Markup Language (XML)

Service Oriented Architecture (SOA) Requirements	
Ref #	**Requirement**
	c. Extensible Stylesheet Language Transformation (XSLT) d. Web Services Interoperability (WS-I) e. WSDL f. SOAP1.1 or 2.0 g. Universal Description, Discovery and Integration (UDDI) h. Web Services (WS)-BPEL i. Representational State Transfer (REST) (in place of SOAP) j. WS-Message Transmission Optimization Mechanism (MTOM) Policy
GTT089	Life Cycle Independence: Each service component should be able to operate in a separate life cycle.
GTT090	Loose Coupling: Service components must be able to be defined independently, with the interface components bridging the gap between components. For example, the Service Consumer Component specification must be defined independent of the Service Provider Component. The alignment of the two specifications is defined in the interface component.
GTT091	The web services must be able to be invoked locally or remotely via invokable interfaces.
GTT092	Communication Protocol: A Service must be able to be invoked by multiple protocols. The choice of protocol must not restrict the behavior of the service. Binding to a specific protocol must take place at run-time/deployment-time, and not at the design or development time.
GTT093	Flexibility: The Contractor must focus on the business processes that comprise the systems, with the following in mind: a. Ability to adapt applications to changing technologies b. Easily integrate applications with other systems c. Leverage existing investments in desired legacy applications d. Quickly and easily create a business process from existing services
GTT094	**Metadata Management:** SOA architecture commonly provides application and data integration via an abstraction layer. Given the requirements of interoperability and independence, the proper use and management of metadata is extremely important to the effective operation of the SOA. It must also allow for: a. Separation of the data and structures and convert them to a data layer within the SOA architecture. b. Achievement of the SOA loosely coupled “separation of concern” approach, by separating the data layer from the application layer to more effectively and easily manage the data without changing the application code. This will create the desired more loosely coupled SOA environment and enable the business to accelerate any system changes required in the future.
GTT095	**Enterprise Service Bus (ESB):** The proposed DMES must include an ESB for data transport, messaging, queuing, and transformation. The ESB is a service layer that provides the capability for services to interoperate and to be invoked as a chain of simple services that perform a more complex end-to-end process. The service layer is designed to handle both normal conditions and respond to failures and adapt to changes. The ESB provides the following functions: ***Message Management.*** This consists of reliable delivery of messages between services and built-in recovery. ***Data Management***. This involves converting all messages between services to a common format, and in turn, converting messages from the common format to the application-specific format within a service. The MITA message format for interoperability is based on XML standards. Information sharing and alert/event notification standards are also defined for allowing information to be aggregated and integrated together. ***Service Coordination.*** This consists of orchestrating the execution of an end-to-end business process through all needed services on the ESB. Services can adapt to changes in

Service Oriented Architecture (SOA) Requirements	
Ref #	**Requirement**
	environments and are supported by a standards-based set of service management capabilities. Services can be simple or complex sets of services that are interconnected by the ESB. There are many different Contractor implementations of an ESB, and the functions included in an ESB vary from one Contractor to another. The list of functions above are key functions needed for realizing an SOA, and are not intended to be all inclusive.
GTT096	**MITA Alignment:** The proposed DMES must be aligned with MITA. This includes, but is not limited to: a. Map of business processes to MITA business processes b. Alignment of proposed business processes to the MITA maturity level and capabilities c. Use of MITA standard interface definitions (expressed in WSDL) and messages (expressed as an XML/schema) for all services d. Use of the MITA/HL7 methodology for defining the information model and messages e. Adherence to the MITA governance process for newly developed interfaces and messages

The Contractor must describe in its proposal how the proposed DMES will meet these SOA requirements. DHSS is interested in future collaboration between Medicaid and other State agencies (e.g., Food Stamps and Temporary Assistance to Needy Families (TANF) and the possibility of shared services and interfaces).

C.3.8 Software License and Maintenance

All software licenses must be in the name of DHSS and must provide for separate development, test and production environments.

Software License and Maintenance Requirements	
Ref #	**Requirement**
GTT097	The Contractor is responsible for all licenses and maintenance use fees throughout the Contract period.
GTT098	All licenses and maintenance use fees will be held by the DHSS and in the Division's name.
GTT099	DHSS's prior approval is required before upgrades, new releases and/or version updates are made to all proprietary and COTS software.
GTT100	The prior approved upgrades, new releases, and/or version updates must be furnished to DHSS at no additional cost. This includes modifications and enhancements to the Contractors proprietary versions and core product used in other States.

C.3.9 Software Escrow

The Contractor must meet the following Software Escrow Requirements:

Software Escrow Requirements	
Ref #	**Requirement**
GTT101	For COTS solutions or where the code will not become the property of the State, the State requires proof of a software escrow agreement. Bidders will acknowledge in their proposal that they have or will have an escrow agreement in force for the solution proposed at the time of contract signature. If this requirement is not applicable for the solution proposed, bidder will explain why.

C.3.10 Change Control

Change Control policies and procedures will be established and approved by DHSS and governed by a Change Control Board (CCB) or Steering Committee staffed by DHSS stakeholders, the State Project Manager, and the Contractor Project Manager. The Board will meet to make decisions and act on change requests, risks, issues, and actions. The CCB will act on those issues that may affect overall project schedule, scope, or funding, as well as those that may require escalation to the Executive Sponsors. The Change Control process provides a framework for, communicating, monitoring, controlling and approving all aspects and phases of this Contract. Contract change orders will also be addressed, but will not focus on any additional payments to the Contractor above and beyond the agreed upon fixed amount of this Contract. The Contractor's overall Change Control process must be described in response to this RFP.

Change Control (CC) also must be in place for all system changes. The change must be tested, approved, documented, validated, and version controlled. The Contractor must operate a CC system to monitor and track all system changes.

Change Control Requirements	
Ref #	**Requirement**
GTT102	All modifications, changes, and updates are made to the Delaware Medicaid Enterprise through a process of Change Control (CC) requests.
GTT103	Provide software to monitor all change requests, track status and progress of change orders, and prepare reports on open/closed requests and prioritized items.
GTT104	The Contractor must respond, in writing, to requests from the DHSS for estimates of system modification efforts and schedule within 10 business days of receipt, unless specified in the CC (which may reduce that time frame) or for large project planning (which may increase that time frame). The response shall consist of a preliminary assessment of the effort (number of programmer and business analyst hours) required to complete the change by SDLC stage. Additionally, externally funded projects will require additional staff and will run in parallel so as to not impact enhancement work.
GTT105	DHSS may or may not choose to pursue certain modification requests. For those DHSS chooses to pursue, the Contractor must prepare a formal design estimate. This estimate will define the problem to be addressed; propose a solution; and specify an estimated level of effort (number of hours) and anticipated schedule required to design, code, test, and implement the change, then approve or revise the request, assign a priority to it, and establish an expected completion date. Additional services may be requested by DHSS and shall be provided on a time and materials, per diem, or other mutually acceptable financial basis as negotiated by project or activity. These activities are anticipated to be in support of State health care initiatives, and may include clerical support to eliminate DHSS backlogs and outreach efforts.
GTT106	Use system approved by DHSS for tracking CCs.
GTT107	Receive system CCs from DHSS.
GTT108	Contractor will return a written statement of understanding within 10 business days of receipt for each CC based on priority of tickets and scope of work assigned by DHSS.
GTT109	System must image and include all attachments pertinent to each CC.
GTT110	System must provide online reporting and status inquiry for any CC, or all CCs in DHSS specified categories.
GTT111	Submit a system change request for Contractor-proposed changes.
GTT112	System must provide automatic notification to affected parties when CC status changes.
GTT113	System must produce reports that are downloadable to other formats, such as Excel.

Change Control Requirements	
Ref #	**Requirement**
GTT114	Provide consultation to the DHSS in the development of modification requests.
GTT115	Conduct detailed requirements analysis for changes, including recommendations, if any, for alternate approaches to meet the DHSS's needs.
GTT116	Develop and submit requirements analysis and specifications to the DHSS for approval.
GTT117	Prepare a reasonable estimate of staff effort and schedule, including impact on other projects and priorities.
GTT118	For minor changes, prepare a description of the required modifications.
GTT119	Prepare and submit a test plan for approval.
GTT120	Perform regression testing to ensure modifications do not affect other areas.
GTT121	Perform acceptance testing and submit test results for review and approval.
GTT122	Organize and provide status and associated information during all status meetings which shall include a presentation by the Contractor Systems Manager on system modification activities. The weekly meeting will allow the Contractor to report progress against schedules and any necessary schedule revisions.
GTT123	Document meetings as minutes.
GTT124	Retain completed work requests for documentation and analytical purposes.
GTT125	Document all status meetings in minutes and provide minutes to DHSS within 2 business days after the meeting.
GTT126	Perform work assignments according to priorities agreed to by DHSS.
GTT127	Verify the successful implementation of the modification, including monitoring accuracy of processing, and correction of any problems.
GTT128	Ensure the integrity of data from prior periods.
GTT129	Prepare, submit, and distribute updates to DMES documentation, user manuals, operational procedure manuals other user documentation, and any other necessary documentation within 15 business days of the date the change goes into production.
GTT130	If the Contractor and DHSS agree that the change request cannot be accomplished using the available staff, the Contractor must respond with a detailed proposal, within 15 business days, containing: a. A statement of the scope of the change request in relation to subsystems, functions, features, and capabilities to be changed b. A breakdown of the work effort by milestone c. A breakdown of the work effort by hour within each job classification required d. An implementation schedule for the change request e. A justification for the additional staff, rates, and schedules

C.3.11 Records Retention

The Contractor must retain all records using an accurate and organized process. These records must be available to DHSS for inspection and review. The Contractor must meet the Records Retention Requirements below:

Records Retention Requirements	
Ref #	**Requirement**
GTT131	Unless DHSS specifies in writing a shorter period of time, the Contractor must preserve and make available with no limitation all other pertinent books, documents, papers and records of the Contractor involving transactions related to the Contract for a period of 7 years from the date of expiration or termination of the Contract.

Records Retention Requirements	
Ref #	**Requirement**
GTT132	All original canceled checks and EFT documentation must be retained for a minimum of 7 years from the date of issuance unless otherwise notified by DHSS; storage must be in the State of Delaware throughout this period.
GTT133	Records and supporting documentation under audit or involved in litigation must be kept for 2 years following the conclusion of the litigation or audit.
GTT134	Maintain online 10 years of payment data, claims history, claims images, and supporting reference data.
GTT135	Maintain online a minimum of 3 years of contact information in the CRM tool.
GTT136	Maintain online a minimum of 6 months of recorded call history and up to 5 years available within 1 business day of request.

C.3.12 User Acceptance Testing

User Acceptance Testing (UAT) demonstrates that the Contractor is ready to perform all required functions for the DMES; that the system satisfies all Contract requirements and CMS certification criteria; and that all reported defects have been corrected by the Contractor and accepted by DHSS. This will also include, but not be limited to, testing of all business processes, COTS products, and business rules engines. Components of the testing will require that the Contractor demonstrate readiness to perform all DMES functions and Contractual requirements, including manual processes.

UAT will be conducted in a controlled and stable environment. The UAT is designed to: test the existence and proper functioning of edits and audits; confirm accounting and federal reporting; verify the coding accuracy of claim records payment and file maintenance; and validate the format and content of all DMES outputs, including, but not limited to: outputs from the DSS for federal reporting, ad hoc reporting and data analysis, all business processes, utilization management, and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

It is DHSS's expectation that the DMES be thoroughly debugged by the Contractor prior to the system being delivered for UAT. The errors discovered should be identified and documented in the defect tracking system.

Letter Certifying that the DE Medicaid Enterprise System is ready for UAT – The Contractor must issue a letter to DHSS certifying that: all data, user manuals, testing facilities, and security accesses necessary to perform UAT have been provided and DHSS must approve of the content of the letter. As stated in the Conversion Plan, the data used for UAT will be based on converted data. The DHSS approved letter is the authorization for the Contractor to proceed to the next testing phase.

User Acceptance Testing Requirements	
Ref #	**Requirement**
GTT137	System must support User Acceptance Testing (UAT) to allow the State to monitor the accuracy of the Medicaid Enterprise and test proposed changes to the system by processing test claim records and other transactions through the system without affecting normal operations.
GTT138	Each system module and process will undergo UAT by the State prior to production implementation.

User Acceptance Testing Requirements	
Ref #	**Requirement**
GTT139	The Contractor is responsible for developing UAT test scenarios, but the State is not limited to these scenarios and will test all aspects of deliverables.
GTT140	The locations for UAT State staff will be at the State's discretion.
GTT141	Upon formal State approval of a module's UAT, it will be scheduled with IRM for implementation into the production environment.

C.3.13 Degree of Customization

In terms of costs, Contractor will be expected to account for necessary customization of proposed solution in order to fit Division business needs.

The degree of customization for COTS products refers to the configuration of the COTS software through user control panels, system settings, and standard configuration files. The State does not allow any changes to the source code of COTS products that would prevent the application of future software version releases or violate software license agreements.

For non-COTS solutions, the degree of customization refers to the amount of source code changes required to the proposed base system in order to meet the Delaware requirements. The State views increased levels of customization as an increased risk to the timely completion of DDI and go-live of the system.

In terms of degree of customization of COTS software to meet State needs, the State prefers that this not exceed 15 percent. There is no metric for this requirement; rather it represents the State's interest in cost containment by restricting the customization of a COTS product. If proposing a COTS solution, please include an estimate of the percentage of customization generally necessary for this type of project. The State will waive ownership rights of customization features if they are made part of the standard product, which in fact is the State's preference.

Degree of Customization Requirements	
Ref #	**Requirement**
GTT142	Degree of customization for proposed software to meet State needs cannot exceed 15%.
GTT143	Solutions must include an estimate of the percentage of customization necessary to meet the project requirements

C.4 General Business Requirements

The Contractor will be expected to address the following requirements in detail. Emphasis is on the limited availability of State staff for this project and the expectation that the Contractor express in detail its understanding of its responsibilities.

C.4.1 Deliverable Standards

The project deliverables need to be delivered to DHSS in a consistent format for timely review and approval. The deliverables and associated documentation must meet the following requirements:

Deliverable Requirements	
Ref #	**Requirement**
GBB006	All Delaware Medicaid Enterprise documentation must follow DHSS approved templates and formatting to ensure consistency. COTS software packages with documentation provided from the Contractor may be excluded provided the documentation meets DHSS approval.
GBB007	All documentation must be submitted to DHSS for approval.
GBB008	Deliverable documentation should be submitted to DHSS in both hardcopy and electronic versions (Microsoft Word and PDF or other formats approved by DHSS)
GBB009	All documentation should be available on a central web based repository for access by the project staff.
GBB010	Any documentation not approved by DHSS must be corrected and resubmitted by the Contractor within 15 calendar days of the transmittal date. The electronic version of the approved documentation must be posted to the project portal site within 3 workdays of DHSS's approval. The Contractor is responsible for providing the copies requested by CMS.
GBB011	The Contractor shall provide the staff necessary to manage the documentation tasks and responsibilities in the manner that meets or exceeds federal, State, and DHSS requirements.
GBB012	The Contractor shall incur all costs required to support documentation task, including facility, staffing, hardware and software costs, printing and distribution of related reports, forms, and correspondence.
GBB013	Documentation must be organized in a format which facilitates updating and any revisions must be clearly identified.
GBB014	Documentation must provide version control for all documentation to maintain historical document archives.
GBB015	Documentation tools must provide ability to print pages, selections, or entire manuals.
GBB016	Documentation must include system, program, and application narratives that are written so that they are understandable by persons not trained in data processing.
GBB017	Documentation must include data model charts and descriptions.
GBB018	Documentation must include Metadata source, descriptions, parameters, and usage.

C.4.2 Contract Accounting Requirements

The Contractor must maintain books, records, documents, and other evidence pertaining to the administrative costs and expenses of the Contract to the extent and in such detail as must properly reflect all revenues, all costs, direct and apportioned, and other costs and expenses of whatever nature as relative to performance of contractual duties under the provisions of this Contract. The Contractor accounting procedures and practices must conform to Generally Accepted Accounting Principles (GAAP), and the costs properly applicable to the Contract must be readily ascertainable.

The accounting system must maintain records pertaining to the tasks defined throughout this Contract and any other costs and expenditures made under the Contract, including correspondence between the parties to this Contract. The Contractor is required to keep all documentation supporting each invoice and deliverable.

Each month the Contractor must provide to DHSS a reconciliation of billed charges for expenses incurred on behalf of the State with 100% accuracy, approved by DHSS.

The Contractor must work with the State to implement a cost allocation plan and document costs as required by federal or State regulations, policy, and/or procedures in a format acceptable to CMS and/or DHSS's staff. This might include, but is not limited to, providing cost

for functional areas and/or tasks according to funding source, programs, and/or functions performed by the Contractor. It may also involve time-studies, tracking call volume, etc.

Allowable direct and indirect costs associated with hourly or cost reimbursement rates must be governed by federal regulation.

Contract Accounting Requirements	
Ref #	**Requirement**
GBB019	The Contractor must maintain books, records, documents, and other evidence pertaining to the administrative costs and expenses of the Contract to the extent and in such detail as must properly reflect all revenues, all costs, direct and apportioned, and other costs and expenses of whatever nature as relative to performance of contractual duties under the provisions of this Contract. The Contractor's accounting procedures and practices must conform to Generally Accepted Accounting Principles (GAAP), and the costs properly applicable to the Contract must be readily ascertainable.
GBB020	The accounting system must maintain records pertaining to the tasks defined throughout this Contract and any other costs and expenditures made under the Contract, including correspondence between the parties to this Contract.
GBB021	Each month the Contractor must provide to DHSS a reconciliation of billed charges to expenses incurred with 100% accuracy, approved by DHSS.
GBB022	The Contractor is responsible for providing cost allocation bases as specified in the DHSS section of the Public Assistance Cost Allocation Plan approved by DHSS
GBB023	For work to be performed on an hourly reimbursement rate or cost reimbursement basis, the allowability of direct and indirect costs must be governed by federal regulation.

C.4.3 Payment for Pass-through Items

Actual expenditures for pass-through items made on the State's behalf will be reimbursed without profit or overhead. The cost of pass-through items is not included in the fixed price per month. Items designated as pass-through items include, but are not limited to:

1. Postage at actual cost
2. Printing at actual costs
3. Communication lines to DHSS at actual cost
4. State owned desktop/laptop hardware software to be procured as a pass-through at actual cost. The specifications for and the quantity of the equipment will be communicated as necessary at the time of equipment procurement.

C.4.4 Auditing Requirements

Specific accounting records and procedures are subject to DHSS and federal approval. Accounting procedures, policies, and records must be completely open to DHSS, State, and federal audit at any time during the Contract period and for 7 years thereafter.

The Contractor must allow for any necessary audits of accounting records and other records regarding Contract performance. In addition, an annual Report on Controls placed in operation and test of operating effectiveness audit must be performed under the Statement on Standards for Attestation Engagements (SSAE) No. 16, and Assurance Reports on Controls at a Service Organization (ISAE) 3402 Reporting on Controls at a Service Organization. This audit replaces the previously required SAS-70 audit.

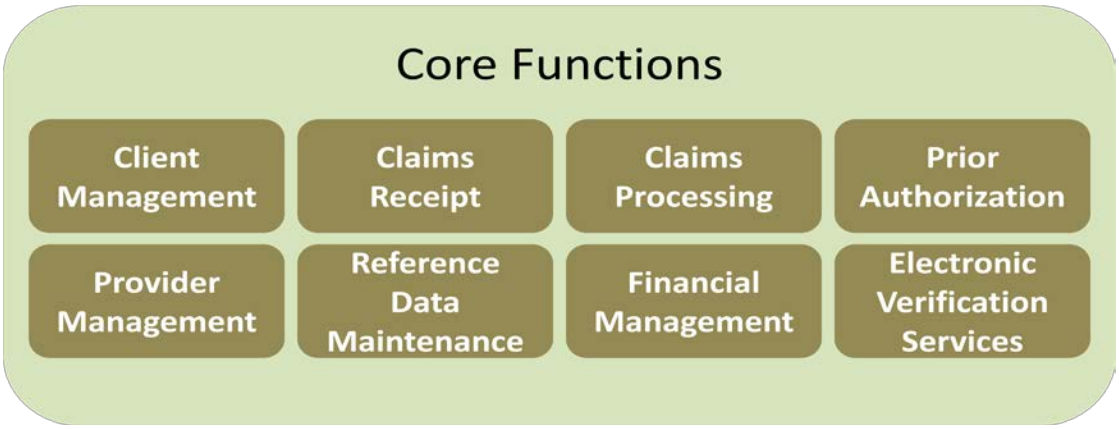
Auditing Requirements	
Ref #	**Requirement**
GBB024	Unless the DHSS specifies in writing a shorter period of time, the Contractor must preserve and make available with no limitation all pertinent books, documents, papers, electronic files and records of the Contractor involving transactions related to the Contract for a period of 7 years from the date of expiration or termination of the Contract.
GBB025	The Contractor must agree that authorized federal, state, and department representatives shall have access to and the right to examine retained records during the seven year post-Contract period or until resolution.
GBB026	Complete and deliver to DHSS an annual Report on Controls placed in operation and tests of operating effectiveness audit performed under Statement on Standards for Attestation Engagements (SSAE) No. 16, and Assurance Reports on Controls at a Service Organization (ISAE) 3402 Reporting on Controls at a Service Organization. DHSS will specify the audit reports and level of detail for the reports delivered to DHSS each year.

C.5 Business Area Functional Requirements

The Business Area Functional Requirements cover the business operations and technical requirements. Embedded in the technical requirements are the Medicaid Enterprise Certification Toolkit (MECT) requirements. The business requirements contain the tasks to be performed by the DMES staff. These business activities are divided into four categories: Core MMIS, Pharmacy Services, Supporting Modules, and Mailroom & Courier services.

C.5.1 Core Functions

The Core Functions area includes many of the traditional MMIS fiscal agent activities. The areas encompass a broad range of activities including client, provider, claims processing, and payment functions.



C.5.1.1 Client Management

The primary purpose of the Client Business Area is to accept and maintain an accurate, current, and historical source of eligibility and demographic information on individuals eligible for Delaware Medical Assistance Programs, and to support analysis of the data contained within Client Data Maintenance Functional Area.

The maintenance of client information is required to support claim processing in batch and online mode, demographic and usage reporting functions, and eligibility verification. Client-related data is also kept in other functional or business areas such as Third Party Liability (TPL), Long Term Care (LTC), Managed Care (MC), Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), Management and Administrative Reporting (MAR), Surveillance and Utilization Review (SUR) and Prior Authorization (PA). The current source of medical assistance eligibility data for the MMIS is a daily file extract from the State eligibility system. The FA processes other client eligibility, for example Delaware Prescription Assistance Program (DPAP), Cancer Treatment Program (CTP), and Buy-In.

The Client Data Maintenance Function Area accepts the following inputs:

1. Client data from the State's eligibility systems
2. Managed Care enrollment information from the State's enrollment broker
3. Primary Care Physician (PCP) selections/assignments from managed care organizations or enrollment broker
4. BENDEX data
5. Buy-In data
6. Online updates of client data
7. Medicare Modernization Act (MMA) file
8. External data files from other State agencies, etc.

Below are some of the Client Business Area objectives:

1. Support the Eligibility Verification System (The EVS requirements are in the Client Checklist.)
2. Maintain and Update Client Information

3. Maintain and Update Buy-In Information
4. Support DPAP Program Process
5. Support DCTP Program Process
6. Maintain EPSDT Information
7. Generate EPSDT Notification Letters
8. Maintain LTC Information
9. Generate LTC Notification Letters
10. Produce Client ID Cards
11. Assist and educate clients regarding their pharmacy benefits
12. Assist and educate clients regarding their dental benefits

C.5.1.1.1 Contractor Business Responsibilities

Client Management – Business Responsibilities	
BEB1	The client pharmacy call center will assist and educate clients about their pharmacy benefits.
BEB2	The client pharmacy call center will be staffed by 10 clinically trained pharmacy technicians that will be available to answer client pharmacy concerns.
BEB3	The call center will be available Monday through Friday from 8:00 a.m. to 5:00 p.m. ET with the exception of State holidays and State emergencies.
BEB4	Determine client eligibility for CTP.
BEB5	Process new client applications for CTP.
BEB6	Operate CTP client call center.
BEB7	Conduct CTP client re-determinations.
BEB8	Maintain post office box for CTP applications.
BEB9	Provider relations staff will process prior authorizations for CTP clients.
BEB10	Process hospice lock-in requests for CTP clients.
BEB11	Generate all letters associated with CTP.
BEB12	Assist with resolution of all Delaware Prescription Assistance Program (DPAP) Part D client calls including, but are not limited to: Part D premium concerns, Prescription Drug Plan (PDP) enrollment discrepancies, and Part D procedures.
BEB13	Serve as liaison for the PDPs to resolve billing and enrollment issues.
BEB14	Provide guidance to the PDPs on State processes and policies.
BEB15	Work with Provider Relations on escalated PDP issues.
BEB16	Provide on-request client counts for non-enrolled PDPs.
BEB17	Assist with resolution of issues between clients and the Social Security Administration (SSA).
BEB18	Assist with resolution of issues between clients and CMS. These calls will include, but are not limited to, calls to CMS on behalf of clients to explain enrollment and response file discrepancies. These calls may or may not be initiated by the client.
BEB19	In accordance with State policies, approve prior authorization requests for emergency supplies of medications, as needed, when there are discrepancies. These will be tracked in the DMES, and the State will be notified when these approvals occur.
BEB20	Notify the Pharmacy Call Center to follow up with the pharmacies for re-billing these medications appropriately when the PDP corrects the enrollment of a client.

Client Management – Business Responsibilities	
BEB21	Assist with resolution of dual eligible Part D client calls.
BEB22	Utilize the IACS or MARx systems to research data discrepancies from the DPAP Response file
BEB23	Access the DMES and correct data discrepancies found within it resulting from the DPAP response monthly file information. Updates to the DMES include, but are not limited to: resolutions of Health Insurance Code (HIC) numbers date of birth, Social Security Number, eligibility, low-income subsidy information, and Part D information.
BEB24	Work the DPAP Response report generated from the DPAP Response file process and coordinate with the DPAPs for appropriate updates.
BEB25	Process and send dual eligibility response file monthly.
BEB26	Utilize the Unix system to research data discrepancies from the Medicaid Modernization Act (MMA) Dual Eligible Response file.
BEB27	Access the DMES and identify data discrepancies found within it from the MMA Dual Eligible Response file. Discrepancies include, but are not limited to: resolutions of Health Insurance Code (HIC) numbers date of birth, Social Security Number, eligibility, low-income subsidy information, and Part D information.
BEB28	Work with all entities on error resolution of the Dual Eligible's Response file and the DPAP Response file. These entities include, but are not limited to: the State Help Desk, caseworkers, and Customer Relations, CMS, SSA, and State-appointed personnel (as a last resort) for making changes to update the Delaware Client Information System (DCIS II). The DCIS II file will then update the DMES
BEB29	Work the MMA Dual Eligible Response report generated from the MMA Dual Eligible Response file process and coordinate with the State to make sure they receive the DCIS II updates.
BEB30	Work with the DPAP staff for outbound client follow-up.
BEB31	Work with the State's Third Party Liability (TPL) Unit to make sure that the DCIS II and the DMES are updated with current TPL information.
BEB32	Attend pertinent Part D related State and CMS conference calls.
BEB33	Become a member of the CMS distribution list, so that Delaware remains on the leading edge of the Part D program.
BEB34	Assess initial operational and systems impact when changes occur in the Part D program.
BEB35	Monitor the Prescription Drug Plan Carrier Discrepancies Report and notify the State TPL Unit, as needed.
BEB36	Provide a quarterly summary of Part D activities to the State.
BEB37	Generate letters to Medicaid for Workers with Disabilities (MWD) clients, sending letters with different verbiage for active clients and pending clients.
BEB38	Generate the MWD premium invoices.
BEB39	Generate disenrollment letters for clients disenrolling in the MWD program.
BEB40	Collect premium payments for Medicaid for Workers with Disabilities from program participants via telephone, Internet, and a lockbox for checks and money orders.
BEB41	Generate welcome letters to newly eligible and newly enrolled MWD clients. Clients will receive a monthly invoice. Past due accounts also will be indicated on the monthly invoice. If coverage is cancelled, a disenrollment letter will be sent to confirm the cancellation.
BEB42	Disenroll clients from the MWD program due to an eligibility or enrollment change in the DMES.
BEB43	Disenroll a client from the MWD program when a death date has been entered in the

Client Management – Business Responsibilities	
	DMES.
BEB44	Disenroll a client from the MWD program when two consecutive monthly premiums have not been paid nor have one non-sufficient funds (NSF) fee and one missed monthly payment.
BEB45	By September 1 of each year, assist DHSS with the development of a form and instructions for how school districts and charter schools should communicate their information related to the free and reduced-price meal programs.
BEB46	By October 1 of each year, communicate the format of the data collection and instructions to each school district and charter school.
BEB47	Before January 1 of each year, create an outreach mailing for each individual who may be eligible for Delaware Healthy Children Program (DHCP) or Medicaid from the file received from the Department of Education (DOE).
BEB48	Before January 1 of each year, families identified during the outreach effort of the previous calendar year will receive their information packets. The packets will include: Letter (generic), Return envelope for the appropriate State Service Center, DHCP/Medicaid application, and a Slim Jim with DHCP program information.
BEB49	By January 31 of each year, track the applications monthly in a report that matches the original list of outreach mailings (for DHCP) to an eligibility report in DMES to determine how many new enrollments result from the outreach and report the data to the Department of Insurance (DOI) and DHSS.
BEB50	Maintain a minimum of 10 years of historical, date specific, client eligibility data, with inquiry capability by client identification number (Master Client Index), case number, Medicare number, Social Security Number (SSN) name or partial name, zip code, county, caseworker, and the ability to use other factors such as date of birth and sex to limit the search.
BEB51	Maintain date-specific Long Term Care (LTC) data by provider (LTC facility) to include: Type of facility (for example, Nursing Facility (NF), Intermediate Care Facility for Mental Retardation (ICF/MR), Institution for Mental Disease (IMD), Assisted Living, and Super-skilled).
BEB52	Update Provider/Client Operations Manual and review annually.
BEB53	Update Client User Manual and review annually with approval from the State.
BEB54	Maintain functionality to identify all eligible children for EPSDT medical, dental, and/or vision services.
BEB55	Generate immunization letters to all eligible families about EPSDT services.
BEB56	Generate all ESPDT information/notification/reminder letters monthly or as specified by the State.
BEB57	Support and maintain functionality to accept eligibility files from State-designated systems/interfaces.
BEB58	Allow online updates for client data changes.
BEB59	Provide current client eligibility, TPL, and other required information to the Electronic Verification System (EVS) and/or claims processing.
BEB60	Provide Buy-In support for enrollment/disenrollment, monitoring, follow-up, and trouble shooting for accretion and deletion problems.
BEB61	Provide staffing to administer the Buy-In function, including: Perform all Buy-In accretion and deletion activities.
BEB62	Transmit all Buy-In requests to Medicare and insurance companies in a compatible file format.
BEB63	Communicate with CMS to resolve Buy-In file discrepancies.
BEB64	Track Buy-In transactions.

Client Management – Business Responsibilities	
BEB65	Accept and process Buy-In files and troubleshoot as necessary.
BEB66	Perform reconciliation of the DMES client file to the DCIS II eligibility file.
BEB67	Research and resolve client file discrepancies, seeking State assistance when necessary.
BEB68	Verify program information through system-generated reports to allow resolution of errors before next monthly Buy-In transmission.
BEB69	Store client and provider applications received by the FA.
BEB70	Support, generate, and distribute all forms, letters, and correspondence related to the DPAP, including but not limited to: applications, brochures, return envelopes, acceptance and denial letters, termination letters, recertification requests.
BEB71	Assign a unique identifier to each DPAP application received.
BEB72	Approve or deny DPAP applications, based on established guidelines and rules.
BEB73	As part of the application process for the DPAP, verify income, proof of residence, and categorical eligibility criteria, such as eligibility for Title XIX and other medical assistance programs.
BEB74	Scan and store client application information for eligibility determined by the FA such as DPAP applications received based on the DHSS retention policy.
BEB75	Return incomplete DPAP applications to applicants with an explanation of the deficiencies and answer calls from applicants when received.
BEB76	Issue identification card to eligible clients and generate replacement cards upon request.
BEB77	Maintain the DMES so that it processes the claim records using approved edit logic, identifies coverage limitations, provides for client co-pays, cost avoids Medicare and pays claim records in the correct amount.
BEB78	Revise all forms and documents as program parameters change or experience shows modifications are required.
BEB79	Maintain all current toll-free telephone numbers and lines to allow access for inquiries and phone applications.
BEB80	Maintain a log of all client calls.
BEB81	Provide adequate staffing to efficiently and effectively operate the DPAP program.
BEB82	Establish and maintain the necessary interfaces with the other programs.
BEB83	Produce required reports in electronic and paper format, as well as allowing online viewing of the reports.
BEB84	Process all DPAP client applicant requests within timeframe defined by the State.
BEB85	Process an application, renewal, or application resolution form and make a determination regarding program eligibility, enter it to the eligibility system, and notify client within 5 business days of receipt of a complete application.
BEB86	Respond to all client requests for applications within 1 business day of the client's request.
BEB87	The telephone system and staff must be able to handle all calls each business day. In addition the system must have answering capabilities when all operators are busy and supply a message to callers during non-business hours. Customer service/enrollment brokers must be available by phone 8:00 a.m. to 4:30 p.m. ET, Monday through Friday each week except for legal State holidays.
BEB88	Staff must be trained in program policy and operations prior to answering calls. At a minimum, staff will receive quarterly training in which State staff will be present.
BEB89	Research and respond to all telephone requests within two business days of request receipt.
BEB90	Provide application assistance by phone (including partially completing applications for,

Client Management – Business Responsibilities	
	and mailing applications to, applicants, as well as, assisting with completions and verifications).
BEB91	Once a client completed application is received, determine eligibility and notify client of disposition within 5 business days.
BEB92	Research and respond to all written correspondence within 5 business days of correspondence receipt.
BEB93	Mail applications and renewals, informational brochures, and replacement identification cards within 1 business day of request receipt.
BEB94	Support and maintain all LTC reports.
BEB95	Identify LTC and Hospice providers due for recertification or review 60 days prior to the due date, as well as follow through with providers to facilitate continued enrollment.
BEB96	Make recommendations on any area in which the Contractor thinks improvements can be made.

C.5.1.1.2 Contractor Technical Requirements

Client Management – Technical Requirements	
BET1	Supports a client data set that contains all required data elements.
BET2	Maintain client demographic data, including, but not limited to: a. Mailing address b. Residential address c. Region code assignment(s) (e.g., county or other) d. Guardian, custodian, representative payee name and address e. Zip Code plus 4 on all addresses f. Date of birth g. Date of death h. Pregnancy date of delivery i. Race(s) j. Sex k. Marital status l. Ethnicity or tribal designation m. Emancipated youth indicator n. Deprivation code o. Primary language spoken p. Primary language for correspondence q. Benefit address r. Custody status s. Telephone numbers (i.e., home, cell, work, guardian and individual ownership of phone) t. Fax number u. Email address – attach email address to client v. Text number or pager number w. Head or member of household x. Foster care indicator y. Foster care for EPSDT mailing indicator z. Others, as determined by the DHSS
BET3	Maintain online access to client characteristics and service utilization information such as once in a lifetime procedures, service frequency on limited services, and indication that TPL resources have been exhausted.

Client Management – Technical Requirements	
BET4	Maintain, at a minimum, the data set prescribed by Part 11 of the State Medicaid Manual.
BET5	Maintain birth date fields that distinguish clients who are over 100 years old from infants.
BET6	Provide an address type and effective dates, for each address maintained in the Client Management Module, and provide the capability to select the type of address when mailings are prepared for clients (e.g., TPL, Explanation of Medical Benefits (EOMBs), EPSDT letters, and prior authorization determinations).
BET7	Processes all transactions that update the client data set on a timely basis as determined by the State, edits fields for reasonableness, and controls and accounts for transactions with errors.
BET8	Collect and accept a file(s) of retroactive changes to TPL, patient liability, and medical eligibility coverage groups from the state, in an agreed upon State approved format and medium, on an agreed upon periodic basis.
BET9	Interface real-time with the State's DCIS eligibility determination system.
BET10	Collect and accept a file(s) of retroactive changes to TPL, patient liability, and medical eligibility from other entities, and make appropriate updates.
BET11	Maintain consistency between MMIS and DCIS for eligibility programs, sub-programs, and aid categories. Make updates required resulting from changes in policy and changes installed in DCIS.
BET12	Properly process, add, change and delete eligibility segments that contain future dates (both effective and end dates).
BET13	Provide the capability to update the Client Management Module with the Medicaid income information supplied by DCIS, via daily online transmission.
BET14	Provide the capability to apply Client Management Module update transactions received from the federal hub (DHS, IRS, and SSA) CMS, DCIS, and keep all eligibility files current. The frequency will be determined by the DHSS.
BET15	Supports management of client information, including archives, with reports, transaction and transaction error tracking, etc.
BET16	Generate reports to meet all federal and State reporting requirements.
BET17	Generate report of active/inactive client summary listings.
BET18	Generate ad hoc reports based on any combination of client parameters.
BET19	Generate report listing possible duplicate clients.
BET20	Generate control and balance reports of daily/weekly/monthly file updates and file reconciliation.
BET21	Generate online audit trail reports of updates and inquiries including the operator ID.
BET22	Maintain online inquiry windows to accommodate the following, using a minimal number of screens, such as: a. Client geographic and demographic information b. Client current and historical eligibility segments c. Client mnemonic name search d. Client SPI status e. Delaware Prescription Assistance Program status f. Pertinent client data, for example, family members g. Client restriction and lock-in data h. Client service utilization data i. Client TPL, Medicare, Health Insurance Premium Payment (HIPP), and Buy-In data
BET23	Create rules engine for client benefit plans and medical eligibility coverage groups.
BET24	Create the ability for easy changes to client benefits plans and eligibility coverage groups.

Client Management – Technical Requirements	
BET25	Support the assignment of clients to DE Medicaid program benefit plans based on rules in the rules engine.
BET26	Support inquiry capability by client identification number, case number, Medicare number, Social Security Number (SSN), name or partial name, zip code, county, caseworker, and the ability to use other factors such as date of birth and sex to limit the search.
BET27	Maintain client related information including, but not limited to, severely and persistently ill (SPI) status, reimbursement level, Buy-In, TPL, patient pay amounts, restrictions (pharmacy, physician, hospice, renal, review, emergency room, fraud, and so forth), and lock-ins (MCO, MCO exemption).
BET28	Maintain client restriction data, including lock-in, to support claim records processing functions, provider inquiries, lock-out indicators, and so forth. This includes a lock-in to limit drug category and ingredient access.
BET29	Maintain windows that provide for a drill down ability, displaying a summary of current eligibility and eligibility related information with indications that there is “more” and/or historical information.
BET30	Create all reports currently created by the MMIS for the MWD program including; a. A report that details MWD premium payments b. A report to list clients who have lost their MWD enrollment for non-payment c. A report that lists refunds to clients d. A report that summarizes MWD program data
BET31	Include MWD data in the client link/unlink process and all reports.
BET32	Include MWD as a selection where eligibility types are displayed.
BET33	The transportation broker process will look at an MWD client’s MWD enrollment before placing an MWD client on the roster file
BET34	The transportation broker eligibility report will look at an MWD client’s enrollment before reporting the client.
BET35	The eligibility response file that is sent on DSCYF clients will look at an MWD client’s enrollment when reporting eligibility.
BET36	The Department of Education Interface eligibility file will be look at an MWD client’s enrollment when reporting eligibility.
BET37	Provide the capability to generate a report if a duplicate client ID number(s) has been assigned to a client.
BET38	Provide the capability to identify and merge duplicate client records, and any associated claims, into one record.
BET39	Provide the capability to identify, track, and unmerge a client record, and any associated claims, to multiple client records.
BET40	Provide the capability to unmerge client records into two separate and distinct records.
BET41	Provide the capability to produce monthly reporting on potential duplicate records and merge statistics.
BET42	Create a process that will disenroll clients from the MWD program due to an eligibility or enrollment change in the MMIS.
BET43	Create a process that will disenroll a client from the MWD program when a death date has been received from DCIS.
BET44	Create client identification cards as prescribed by the DHSS.
BET45	Provide method for request of replacement cards through the DE web services portal.
BET46	Receives and processes Client 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

Client Management – Technical Requirements	
	and synchronization. Applies reconciliation changes to master file. Produces a file of changed records to be sent to originating source.
BET47	Perform reconciliation of client files with DCIS monthly and as directed by the State.
BET48	Archives Client data sets and updates transactions according to State provided parameters.
BET49	Maintain online access to client history for 10 years of historical data with a rolling 11th.
BET50	If the EPSDT reporting process is performed by the MMIS, it provides Client data to support case identification, tracking, and reporting for the EPSDT services covered under Medicaid (optional).
BET51	Provide the capability to perform the following DE EPSDT functions, including but not limited to: a. Client demographics and program eligibility (in conjunction with the Client Eligibility function) b. Returned EPSDT notification responses c. Periodicity schedules for ongoing screening due notifications d. EPSDT outreach and informing letters e. Paid claim records data from the Claims Processing functions f. ICD-CM procedure codes, CDT, Current Procedure Terminology (CPT), Healthcare Common Procedures Coding System (HCPCS) procedure codes and locally created codes [including Electronic Claim Submission (ECS) from the DPH Immunization Registry] g. HCFA-1500 and American Dental Association (ADA) Dental form in electronic or paper format h. Provider file data i. Fee schedule data j. ISIS - Part C eligibility data k. Encounter claims data for managed care providers l. UB-04 billing forms (with preventive diagnostic and treatment services) m. PA data from the Prior Authorization function
BET52	The Delaware MMIS must support the EPSDT program with capabilities that draw on both fee-for-service and MCO encounter data information sources.
BET53	Provide the capability to maintain all EPSDT program eligibility records.
BET54	Provide the capability to identify EPSDT-eligible families.
BET55	Provide the capability to automatically generate reports to State providers on EPSDT eligible children due for screenings based on the periodicity schedule.
BET56	Provide the capability to generate immunization letters as well as annual notices to all eligible families about EPSDT services.
BET57	Provide the capability to enroll EPSDT providers and identify them as EPSDT providers.
BET58	Provide the capability to maintain, for each EPSDT eligible client, the screening results, immunization status, referrals, and diagnosis and treatments for abnormal conditions identified during the screenings.
BET59	Provide the capability to provide a mechanism to track whether or not enrollees who are eligible for EPSDT services receive screenings and related referrals.
BET60	Provide the capability to track children's immunization status.
BET61	Provide the capability to support the automated generation of follow-up or reminder correspondence to clients about upcoming or overdue appointments and other events, initial and follow-up letters about EPSDT benefits, schedules for well-child exams and immunizations, and other related information and events.
BET62	Generate and mail all ESPDT information/notification/reminder letters monthly or as

Client Management – Technical Requirements	
	specified by the State.
BET63	Provide the capability to provide online inquiry to EPSDT data with access by client ID or SSN, to include, but not limited to, such areas as: a. EPSDT eligibility periods b. Notification dates c. Notification responses d. Screening dates e. Screening results f. Screening providers (health care providers of medical, dental, vision, and hearing screenings) g. Primary care physician (PCP) h. Procedure codes i. Date of service j. Referred services
BET64	Provide the capability to identify screening claim records adjudicated during claims processing.
BET65	Provide the capability to process claim records for diagnosis and treatment services, including non-covered services (OBRA 89 services for services outside the State Plan).
BET66	Provide the capability to track and report services provided both within the State Plan and outside the State Plan.
BET67	Provide the capability to identify abnormal conditions, by screening date, and whether the condition was treated or referred for treatment.
BET68	Provide the capability to track abnormal conditions that have been referred but not yet treated, to claim records submitted for the client, until all abnormal conditions have been treated or the State specifies that tracking should be stopped.
BET69	Provide the capability for online update and inquiries to client EPSDT data with screening results and dates, and referral and treatment dates for abnormal conditions with access by SSN or client ID.
BET70	Provide the capability to accept online updates of notification responses, screening information, and periodicity schedules.
BET71	Provide the capability to generate an extract of paid claim records for EPSDT paid services, in an agreed upon format and medium, on an agreed upon periodic basis, to the State.
BET72	The proposed system must be capable of retrieving data necessary to generate outputs that support all EPSDT information needs. All reports must be made available online and through media specified by the State.
BET73	Create report for data from EPSDT screenings, screening results, treatment provided, provider name and all dates associated.
BET74	Create reports to meet all federal and State reporting requirements, including CMS-416 reporting specifications drawing from fee-for-service and MCO encounters including specially approved NDCs.
BET75	Generate the mandated federal EPSDT report (CMS-416) by the annual due date in the federally required format, including EPSDT screens, performed and reported by MCOs.
BET76	Create management reports which can be ordered alphabetically by the head of the assistance unit with children identified under assistance unit, which include English language descriptions of report data, and which detail the following: a. Screenings performed b. Abnormalities found c. Immunizations delivered d. Dental procedures performed

Client Management – Technical Requirements	
	e. Orthodontic procedures performed, including date of approval f. Referral treatments recommended and initiated g. Age groupings and geographic summaries of the above h. Summary screening and results reports i. Detailed EPSDT-related services reports, by client, on request j. Number of days between screening and referred treatment k. Immunization status report showing timely/untimely Immunizations for children ages zero through twenty l. Report of fully immunized children ages zero through twenty m. Initial and periodic notification documents n. Listing of EPSDT providers, using changeable select and sort parameters o. Screening cost analysis, by screening provider, showing utilization and expenditure data p. County-by-county cost comparisons report between children receiving services who were screened, by each screening type, versus those receiving services with no screens, include dental, hearing, and vision q. Health status analysis reports, by district and geographic region, using key child health indicators such as procedure codes or claim form indicators to identify health status such as immunized children r. Expenditures for children who were screened compared to those who were not screened s. Untreated abnormalities after 30 days and 60 days, by client t. Provider EPSDT service participation information, by geographic region, specialty, and sub-specialty u. Other utilization and cost reports as defined by the State
BET77	Create non-participation and other monitoring/tracking reports as necessary.
BET78	Provide the capability to use the workflow management engine to provide and log notices, track services provided, and enter case notes for each EPSDT-eligible client, and, at a minimum, include processes listed below: a. Automatically generate EPSDT notification letters according to specifications set by the DHSS b. Identify the family head of household or foster care worker and generate EPSDT screenings letters to this individual, even if the child resides at a different address c. Retrieve data from the MMIS claims and encounter data (if applicable) to compare to services recommended from the periodicity table d. Provide for the inclusion of claims attachments with links from EPSDT well child screens e. Automatically compare and report claims to the periodicity table, to determine if the child received the health checkup examination and related services at the recommended intervals
BET79	Provide web-based query and management screens to make it easy for DHSS and Contractor staff to know the next steps due according to the workflow.
BET80	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.
BET81	Provide the capability to maintain date-specific data necessary to support long term care claims processing, such as level of care, patient financial responsibility, admit and discharge dates, home-leave days, and hospital leave days.
BET82	Maintains record/audit trail of a client's requests for copies of personal records (including time/date, source, type, and status of request).
BET83	Maintains record/audit trail of errors during update processes, accounting for originating

Client Management – Technical Requirements	
	source and user.
BET84	Provide the capability to maintain an audit trail to document date, time, and authorized user who updated the client record.
BET85	Provide the capability to maintain an audit trail to document each modification and/or correction made to the Client Management Module, the date the modification and/or change was made, and the identification of the person making the change.
BET86	Allows for authorized users to update client records online.
BET87	Provide online update, add, and deletion capabilities to client information by appropriate users.
BET88	Provide role-based security to maintain control over all client data access and updates.
BET89	Maintain an audit trail for any updates made to client information and also include user ID of last update.
BET90	Provide the capability for authorized users, to submit online, eligibility updates and income changes for MAO clients, to the Client Management Module.
BET91	Supports and tracks the identification of duplicate client records based on State-defined criteria.
BET92	Identify potential duplicate client records using both current and historical identification numbers and information.
BET93	Provides data storage and retrieval for Third Party Liability (TPL) information; supports TPL processing and update of the information.
BET94	Provide the capability to maintain insurance coverage data in the Client Management Module, including, but not limited to: a. Carrier b. Policy number c. Group number d. Pharmacy Benefit Manager (PBM) ID and client identification number e. Sponsor, subscriber, or policyholder name/identification number(s) f. Type(s) of coverage g. Dates of coverage h. Date the coverage was added to the database i. Date the coverage was updated j. Court order, including date ranges and responsible payer k. Part D Enrollment Indicator; The record should indicate the member is enrolled in Medicare Part D and identify the plan the client is enrolled in l. Allow for multiple insurance policies
BET95	Provide the capability to maintain a historical record of benefit assignment(s) for a client, including identifying dual-eligibility spans.
BET96	Supports the assignment of clients to Medicaid benefits/benefit packages based on federal and/or State-specific eligibility criteria.
BET97	Provide for the MMIS eligibility process to recognize the Medicaid for Workers with Disabilities (MWD) Program aid category and allow this aid category to overlap with other State-only programs.
BET98	Maintain an MWD enrollment indicator and update when enrollment is added or has ended.
BET99	Create client eligibility screens to allow for all aid categories and to allow for the valid overlap of aid categories.
BET100	Display an indicator for MWD enrollment that also has the functionality to prevent MWD clients from receiving a Medicaid eligibility card.

Client Management – Technical Requirements	
BET101	Create and maintain a screen in the MMIS for enrollment of Medicaid for Worker Disabilities clients.
BET102	Provide for a daily enrollment process to add MWD enrollment data for any client added to the system with an MWD aid category.
BET103	Provide for the weekly Medicaid certificate process to check a client's MWD enrollment.
BET104	Create all client letters currently in use by the DHSS, including MWD communications.
BET105	Assign newborns to same MCO as the mother, following all policy and rules for eligibility and capitation payments.
BET106	Provide for maintenance of information to reflect completed reviews on MCO enrollment/reenrollment and other client reviews.
BET107	Provide for an online updateable notes function within the client management functional area and retain these notes with the client's history.
BET108	Provide the ability to automatically generate all standard and routine client correspondence and the flexibility to draft and generate non-standard correspondence.
BET109	Create disenrollment letters for clients disenrolling in the MWD program and any other special program requiring special disenrollment letters.
BET110	Allow Client Management Module to be searched by all available data elements.
BET111	Store separate indicators for language spoken and correspondence language for each client.
BET112	Provide the capability to maintain a record of client co-pays (cost-sharing). Co-pays must follow benefit plan spans.
BET113	Maintains record of benefit assignment(s) for clients.
BET114	Maintain a client eligibility, provider, reference, and financial session, that at a minimum communicates the following information: a. Eligibility status for the date queried b. Third party payers who must be billed prior to Medicaid c. Client participation in a managed care program d. Check write information e. National Drug Code data including coverage and quantity f. Client sex and date of birth g. Client specific claim status h. Program and service restrictions such as prior authorization and lock-in, and provides the appropriate safeguards, including: i. Limiting access to eligibility information to enrolled Delaware medical providers and authorized State personnel only ii. Protecting the confidentiality of all client information iii. Maintaining an audit trail of all inquiries and verification responses made, the information conveyed, and to whom the information was conveyed
BET115	Support a universal identifier, for clients across all benefit plans, and cross-reference that identifier with all prior established benefit plan identifiers.
BET116	Provide the capability to cross-reference all members of a case to a case number, and provide the capability to identify all members of a case, and identify and link parent and children for other MMIS processes.
BET117	Provide the capability to post retroactive eligibility segments sequentially.
BET118	Provide the capability to receive and process weekly updates for client nursing home authorization data.
BET119	Maintain date-specific LTC data by client, to include: a. Admission and discharge dates

Client Management – Technical Requirements	
	b. Social and hospital leaves of absence and hospital hold days c. Medicare days d. Patient-pay liability information e. Patient reimbursement level f. Client placement level (ICF, SNF, ICF/MR, ICF/IMD, Assisted Living, and Superskilled) g. Diagnosis codes h. Quarterly resident review status i. Facility identification and effective dates j. Pre-admission screening information
BET120	Interface in an online, real-time mode with DCIS to obtain eligibility, financial, and LTC data.
BET121	Utilize the client data access function to request and accept client-related LTC data to support the LTC processing function online screens, eligibility verification, and claim records processing.
BET122	Maintain maximum current and historical (minimum of 10 years) LTC data to support transaction processing and reporting.
BET123	Identify patient payment amounts, current and retroactive changes, Medicare and other third party resources, and deduct them from payments to providers when appropriate and maintain patient liability balances for the month.
BET124	Provide the ability to identify the provider or managed care facility to receive the patient payment monies.
BET125	Provide capability to pro-rate patient payment amounts and payments to nursing homes.
BET126	Track leaves of absence (bed hold days) for both social and hospital stays. The system should display an online summary of patient leaves by date(s) and type of leave, as well as whether the leave was approved or denied.
BET127	Limit the leaves of absence to 14 days per 30-day period per year for hospital and 18 for social per year, unless waived, based on the first date of leave for each category.
BET128	Provide a LTC client eligibility summary page that includes eligibility status, patient payment amount, bed hold data, begin and end dates, leaves of absence, nursing facility, and race code.
BET129	Provide the ability to automatically link patient-specific data for patients that move from LTC coverage to Hospice Care coverage. (The Hospice Care Organization is then required to pay the costs of the LTC facility and to collect the patient payment amount.)
BET130	The MMIS should generate a letter/notice to the appropriate hospice agency informing the agency of any hospice patient's patient payment amount and any change in patient payment amount.
BET131	Provide the ability to update the MMIS after receipt of date of death information.
BET132	Use the latest version of the Minimum Data Set for capturing patient-specific data.
BET133	Maintain information for Home-and Community-Based Waiver Services (HCBS) program clients, including prior placement and tracking of services, expenditures, and so forth.
BET134	Provide the ability to create all required CMS-372 report data for HCBS waiver program.
BET135	Provide processes and data to meet, at a minimum, the requirements in Part 11 of the State Medicaid Manual.
BET136	Create the ability to retrieve data necessary to generate outputs and report for Long Term Care programs.
BET137	Generate report to include, but not be limited to: a. Analysis of leave days, by facility type and leave day type b. LTC facility rosters

Client Management – Technical Requirements	
	c. Tracking of non-bed-hold discharge days d. Recertification's due within 60 days e. Facility rosters for all facilities that are at, over, or nearing State-defined capacity thresholds for specified diagnosis codes f. Hospital claim records/bed-hold analysis/comparison g. Reports generated by diagnosis h. Non-payment by facility, for lack of pre-admission screening i. Paid days of care by month of service, by facility, by program, and indicating days of care covered by patient payment amounts and other payers
BET138	Create online inquiry screens which minimally accommodate the following: a. Inquiry to client LTC data with access by client ID and provider ID b. Inquiry to client LTC data with access by facility, selecting clients with MI/MR indicators c. Current and historical LTC data segments to accommodate 5 years of processing
BET139	Provide the capability to maintain date-specific data necessary to support long term care claims processing, such as level of care, patient financial responsibility, admit and discharge dates, home-leave days, and hospital leave days.
BET140	Provide the capability to support different notifications to be sent to clients, by program (e.g., LTC, HCBS, and EPSDT).
BET141	Applies appropriate benefit limitations for clients based on federal and/or State-specific criteria.
BET142	Maintains record of client benefit limitation information.
BET143	Calculates and applies client cost-sharing (including premiums and co-pays) for particular benefits based on federal and/or State-specific criteria.
BET144	Create client invoices for MWD clients and any other special program requiring invoices be sent to the client.
BET145	Maintains record of client cost-sharing.
BET146	Maintains record/audit trail of any notice of benefit(s) sent to clients (including time/date, user/source, and reason for notice).
BET147	Provide the capability to create labels on demand, for mailings to support outreach efforts.
BET148	Provide and maintain an agency-wide case tracking application for grievances and appeals.
BET149	Provide the capability to image and track all documents received from clients and make these documents available to authorized DHSS and Contractor staff.
BET150	Provide the capability to identify clients through all fields, as identified by the DHSS.
BET151	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).
BET152	Provide eligibility information on the web portal and make it available to providers and other users authorized by the DHSS.
BET153	Provide the capability to maintain a database of client eligibility to support provider inquiry and billing (e.g., eligibility voice response, dial-up eligibility verification inquiries, or point -of-service).
BET154	Provide the capability for clients to access an online provider locator listing on the web portal.
BET155	Maintain online access to client eligibility data, claim records status, most recent check write prior authorization information, National Drug Code coverage and quantity, and other information and generate date-specific requests for the above-listed data.

Client Management – Technical Requirements	
BET156	Allow inquiry through a mother's identifier for verification of a newborn's eligibility.
BET157	Allow inquiry of data by the following identifiers: a. For client information i. Client identification number ii. Two of the following: Client full name, including middle initial, client date of birth; or client SSN b. Claim status information by client identification, date of service
BET158	Limit access to verification inquiries for dates of service within the preceding 24 months.
BET159	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).
BET160	In response to an eligibility inquiry made through the MMIS, provides notice of participation in a managed care program (SMM 11281.1B).
BET161	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).
BET162	Maintain the EVS system to check a client's MWD enrollment before returning an eligible response.
BET163	The inputs to the EVS include the following: a. Online and voice responses containing the most current client data available, including TPL, eligibility segments, claim records status, prior authorization information, and so forth b. The most current MMIS provider data available, including the most recent check write c. Reference data inquiry capability for pertinent procedure, diagnoses, drug code and other coverage and limitation information d. Provider maintenance data e. Claim records
BET164	Maintain an access, for enrolled Delaware medical providers, including those located within and outside the State of Delaware, through the use of their own dedicated or dial-up telephone line, compatible mainframe computer or mini-computer, and modems, through the public switched telephone network, to the EVS.
BET165	For those providers with touch-tone telephone service, maintain an interactive, client electronic verification session, through the use of an articulated automated voice response system.
BET166	Maintains record/audit trail of responses to eligibility inquiries.
BET167	Provide the capability to maintain a record/audit trail of responses to eligibility inquiries, from any source, such as, but not limited to: voice, fax, email, web portal, or written correspondence. If eligibility inquiry is done by written correspondence, the original document must be maintained for fair hearing concerns and DHSS staff must be able to easily view and print all documents.
BET168	Provide the capability to log a date that the record is sent to any external source.
BET169	Supports system transmission and receipt of all current version X12N and NCPDP eligibility verification transactions.
BET170	Supports production of X12N 270 transactions to query other payer eligibility files and ability to process responses.
BET171	Provide the capability to respond to queries on client eligibility and benefits status by supporting X12N 270/271 transactions.
BET172	Allow read, write, edit, and delete Client Management Module access, granted according to established principles related to and governed by privacy and security standards.
BET173	Identifies and tracks potential Medicare Buy-In clients according to State and CMS-

Client Management – Technical Requirements	
	defined criteria.
BET174	Transmits State-identified Buy-In client information for matching against CMS-specified federal Medicare client database(s).
BET175	Provide a monthly extract of clients that are dually eligible for Medicare and Medicaid, to CMS and other carriers as specified by the DHSS.
BET176	Transmit, on schedules specified by the State, Buy-In requests to Medicare, in a format compatible with these entities.
BET177	Process premium payments to Medicare and health insurance companies as directed by the State.
BET178	Accepts Buy-In client response information from CMS-specified federal Medicare client database(s).
BET179	Perform automatic updates of both Part A and Part B Medicare segments when the client is accreted.
BET180	Processes change transactions to update Buy-In client information. Identify and track errors or discrepancies between State and federal Buy-In client information.
BET181	Maintain an automated audit trail of all Buy-In transactions.
BET182	Provides Buy-In client information for program or management use, including: a. Transactions processed b. Errors identified c. Error correction status d. Medicare premiums to be paid by client
BET183	Generate and forward to the appropriate State unit Medicare Buy-In and audit trail reports.
BET184	Tracks Buy-In exceptions for those clients who are identified as eligible, but whose premiums have not been paid.
BET185	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 (LIS) eligible clients for the purposes of cost-avoidance on prescription drug claims and calculating spend-down payments.
BET186	Maintain online access to Buy-In files.
BET187	Provide the ability to enter notes and track on Buy-In processing and errors including the date and reason for the errors.
BET188	Provide the capability to maintain current and historical information, with inquiry and update capability, for authorized DHSS users, on Medicare Part A, B, C, D, including, but not limited to: a. Effective dates b. Termination dates c. Medicare identification number d. Medicare advantage plan information e. Part D PBM information f. Other health plan information g. Medicare Buy-In information h. Part D subsidy information i. Part C information j. Other information, as defined by the DHSS

C.5.1.2 Provider Management

The Provider Management Area focuses on recruiting potential providers, supporting the needs of the population, maintaining information on the provider, and communicating with the provider community. The goal of this business area is to maintain a robust provider network that meets the needs of both the provider communities and DMAP clients, and allows the State to monitor and reward provider performance and improve healthcare outcomes.

The Provider business processes serve as the control point and central source of information on all providers and provider applicants. The National Provider Identifier (NPI) is the identification of record. Files are maintained that provide comprehensive information on each provider, billing agency, trading partner, and provider group participating in the State programs.

Objectives of the Provider Management Business Area are:

1. Encourage the participation of qualified providers by making enrollment and re-enrollment an efficient and accurate process.
2. Perform provider screening, revalidation, enrollment, and re-enrollment.
3. Maintain a Provider Relations Call Center for providers, clients, and other inquiries.
4. Provide software to providers for use of the EVS and ECS.
5. Provide for the processing of provider contracts and changes in a timely and accurate manner.
6. Maintain control over all provider data.
7. Maintain all demographic and rate information to support claims.
8. Maintain an online provider directory.
9. Train providers.

C.5.1.2.1 Contractor Business Responsibilities

Provider Management – Business Responsibilities	
PRB1	Provide an adequate number of trained Provider Relations staff, knowledgeable in DMAP policy, procedures, and claims submittal process.
PRB2	Enroll providers in the DMAP in accordance with the certifications, documentation, verification, special notes, and all the parameters and settings required by DMAP.
PRB3	Maintain up-to-date provider enrollment application forms on the DMAP website and in print version.
PRB4	Receive requests for enrollment and prepare enrollment packets and contracts for mailing to providers.
PRB5	Process all provider applications received and enroll according to State policy and procedures.
PRB6	Print provider agreement, or provide form for signature on the DMAP Website.
PRB7	Notify providers of acceptance/rejection as a Delaware Medicaid provider.
PRB8	Prepare for enrolled providers a start-up packet containing all the information for participation in the Delaware Medicaid program.
PRB9	The FA's Provider Enrollment staff will track provider applications and obtain all documents and verifications needed to process enrollment.
PRB10	Perform provider re-enrollment procedures.

Provider Management – Business Responsibilities	
PRB11	Verify required licenses and certifications.
PRB12	Track the provider application process through final disposition of the application.
PRB13	Operate and maintain the Provider Data Maintenance function, including the maintenance of a provider master data set or master file.
PRB14	Provide training in the use of the Provider system to State personnel annually and within 30 days of request by the State.
PRB15	Conduct mass updates of the provider file when directed to do so by the State.
PRB16	Scan and store all forms, certificates, attachments, etc., associated with a provider application.
PRB17	Maintain an automated case notation and tracking system for all provider and client inquiries (verbal and written). Staff will be able to enter, at the minimum, inquiry details, the date of the inquiry, the provider ID, the form of the inquiry (written, telephone, or in person), the specific nature of the inquiry, the form of the response, the date of the response, the respondent, and relevant comments. The system shall store this information, at a minimum, by date of inquiry, the primary MMIS area (for example, recipient, provider, SUR, TPL, appeals), and provider or client identification.
PRB18	Maintain provider training and recruitment plan and update the plan annually.
PRB19	Hold provider training sessions for new providers or for providers requesting training and/or at the direction of the State.
PRB20	Identify providers in need of training (e.g., new providers, providers with abnormally high number of denied or suspended claims, or high error rates). Review appropriate reports weekly for indicators defined by the State and schedule training sessions.
PRB21	Develop, distribute, and evaluate survey for providers to review and report on effectiveness of provider training sessions.
PRB22	Maintain a positive rapport and open communications with the provider community.
PRB23	Maintain Provider Relations Call Center in accordance with the performance requirements to be defined by the State.
PRB24	Provide performance reports on Call Center activities to the State.
PRB25	Maintain record of providers that participate in training sessions.
PRB26	Conduct provider site visits on an as needed basis.
PRB27	Make available all forms unique to the Delaware Medical Assistance Program on the DMAP website with the capability to be completed online by providers, as directed by the State.
PRB28	Maintain up-to-date provider billing manuals, procedure and user manuals, and training materials on the DMAP website for providers to access and retrieve.
PRB29	Annually review provider billing manuals, procedure and user manuals, and training materials, update if changes occurred, and submit for State approval.
PRB30	The FA is responsible for producing quarterly newsletter.
PRB31	Make quarterly provider newsletters available on the DMAP website.
PRB32	Annually distribute State-approved provider satisfaction questionnaires to all active providers.
PRB33	Make recommendations on any area in which the Contractor thinks improvements can be made during the biweekly FA status meeting.
PRB34	Implement all DMES supported, Clinical Laboratory Improvement Amendment (CLIA) functional requirements as requested by the State.
PRB35	Obtain CLIA-related data extracts, and updates from CMS.
PRB36	Maintain provider and reference data used to support the DMES processing of laboratory claim records in accordance with CLIA requirements.

Provider Management – Business Responsibilities	
PRB37	Process complete provider applications within 5 business days of receipt.
PRB38	Have trained provider representatives visit new, in-State providers, (first time enrollee not including new individuals enrolling in an existing group) within 10 business days of application approval.
PRB39	Develop, maintain, and update, within 2 business days, provider enrollment criteria developed as directed by the state.
PRB40	Staff provider relations phone lines with trained personnel from 8:00 a.m. to 5:00 p.m., ET, Monday through Friday.
PRB41	Maintain a sufficient number of telephone lines to answer provider inquiries so that no more than 5% of incoming calls ring busy or are on hold for more than one minute.
PRB42	Respond to incomplete telephone inquiries within two business days with an interim answer, and a final response within 14 calendar days when follow-up is needed.
PRB43	Respond to written correspondence with at least an interim answer within five business days of receipt and a final response within 14 calendar days of receipt.
PRB44	Test and report results of electronic billing, automated remittance, and electronic fund transfer options within 5 business days of a provider's written notice that he is ready to test.
PRB45	Provide copies of provider inquiry logs and a summary report to DHSS on a monthly basis.
PRB46	Generate and mail 1099s no later than January 31st of each year.
PRB47	Perform B Notice procedures and mail appropriate notices.
PRB48	Answer provider inquiries.
PRB49	Provide secure online access to the entire DMES for other State Agency's Benefit Programs to inquire and update client eligibility, lock-in status, view claim records/history, retrieve reports, and/or other criteria for each of the programs at the agencies' location.
PRB50	Enroll providers who provide services for other State Benefit Programs.
PRB51	Receive, accept, and adjudicate claim records from other State Agency Benefit Programs.
PRB52	Generate letters for other State Agency Benefit Programs.
PRB53	Establish and maintain the necessary interfaces for other State Agency Benefit Programs.
PRB54	The FA will electronically retain provider inquiry forms including responses for 5 years.
PRB55	Log and send provider appeals for denied claims or PAs to DHSS for resolution, and track to completion.
PRB56	Maintain 100% accuracy rate for all provider and client correspondence (written and electronic) in accordance with State law and regulations.
PRB57	Provider Relations staff shall properly document all customer contact in the CRM tool with complete and accurate information.
PRB58	The customer service representatives must be available for "walk-in" providers or clients during normal business hours from 8:00 a.m. to 4:30 p.m., Monday through Friday, excluding DHSS holidays.
PRB59	Provide a DHSS approved training program to ensure that all staff are adequately trained in their responsibilities and DHSS policies prior to beginning operations. Ensure that a continuous training program is in place to maintain their knowledge and understanding of system and policy changes that affect procedures.
PRB60	Provide a weekly stakeholder summary report to DHSS listing the top issues for each stakeholder group (e.g., client, provider, pharmacy).

C.5.1.2.2 Contractor Technical Requirements

Provider Management – Technical Requirements	
PRT1	Provides secure access to the applications.
PRT2	All additions and updates to provider information must be password protected and only available to authorized users.
PRT3	Routes provider applications, and collects and processes provider enrollment and status information.
PRT4	Maintain provider participation agreements, certification and licensing documentation in easily retrievable electronic format.
PRT5	Produces notices to provider applicants of pending status, approval, or rejection of their applications.
PRT6	Provide the ability to automatically generate all standard and routine provider correspondence and provide the flexibility to create non-standard correspondence.
PRT7	Identify and report providers (individual or group), that have initiated the enrollment process, but have failed to return required information necessary to complete the enrollment into the Medicaid Program.
PRT8	Identify and alert authorized users of those providers who failed to submit the required paper application and/or attachments, and signed contract, via mail.
PRT9	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.
PRT10	Identify/prevent entry of individual (Type 1) providers with multiple NPIs.
PRT11	Flags and routes for action if multiple internal State assigned provider numbers are assigned to a single provider.
PRT12	Create the ability to assign a unique tracking number to each provider enrollment application or correspondence document.
PRT13	Edit to prevent duplicate provider enrollment during an update transaction.
PRT14	Document, review, and resolve duplicate provider identification numbers and support the linking of duplicate numbers to eliminate redundant reporting of resolved suspect duplicates.
PRT15	Identify potential duplicate provider records using both current and historical identification numbers and information.
PRT16	Produce reports of providers attempting to receive additional provider numbers.
PRT17	Provide a free-format unlimited space comment or notes field or screen.
PRT18	Supports communications to and from providers and tracks and monitors responses to the communications.
PRT19	Supports a provider appeals process in compliance with federal guidelines contained in 42 CFR 431.105.
PRT20	Supports automatic generation of appeals opportunities when a provider is rejected.
PRT21	Maintains date-specific provider enrollment and demographic data.
PRT22	Maintain and define provider enrollment status codes with associated date spans to include but not be limited to: a. Application pending b. Enrolled for all programs c. Enrolled only for special programs d. Specific provider arrangement e. Change of ownership f. Limited time-span enrollment

Provider Management – Technical Requirements	
	g. Out-of-state and border providers h. Enrollment suspended i. Terminated - voluntary/involuntary
PRT23	Provide the capability to receive and process: a. Provider enrollment application forms, including licensing and certification information b. Documentation of licensure, certification, SSN, and EIN c. Provider update transactions d. Disclosure of ownership forms/data e. Changed provider information from providers, the State, HCFA, and CLIA f. Provider inquiries g. Financial payment, adjustment, and accounts receivable data from the financial processing function of the MMIS h. Provider screening
PRT24	Provide the capability to add new provider types and taxonomies with all the necessary parameters, including but not limited to, valid claim types, valid claim forms, valid type of bill (UB-92), State Category of Service, Federal Category of Service, funding source, and valid procedure codes using a user friendly online method.
PRT25	Display basic information about a provider displayed on a single screen as determined by the State (for example, name, location, number, program, provider type, taxonomy, certification dates, and effective dates).
PRT26	Scan, index, and electronically store copies of all provider enrollment documentation.
PRT27	Provide the ability to track provider enrollment over multiple plans and track total enrollment by site, system, or plan.
PRT28	Generates information requests, correspondence, or notifications based on the status of the application for enrollment.
PRT29	Generate notices automatically to providers, including, but not limited to: status change, approvals, denials, sanctions, license expiration, and provider's rights to appeal, as determined by the DHSS.
PRT30	Tracks the sending of State furnished information to enrolled providers.
PRT31	Produces responses to requests/inquiries on the adequacy of the Medicaid provider network based on provider/Client ratios by geographic region, provider type, etc.
PRT32	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.
PRT33	Provide for a simplified enrollment process.
PRT34	Accept electronic signature on enrollment without hard copy, as allowed by DHSS and federal regulations.
PRT35	Provide the capability to tie provider correspondence documents to appropriate enrollment application, when applicable.
PRT36	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.
PRT37	Tracks and supports any established provider review schedule to ensure providers continue to meet program eligibility requirements.
PRT38	Verifies provider eligibility in support of other system processes (i.e., payment of claims).
PRT39	Identify by provider any applicable type code, plan code, location code, practice type code, category of service code, and taxonomy code which is used in the Delaware Medical Assistance Programs (DMAP), and which affects provider billing, claim pricing, or

Provider Management – Technical Requirements	
	other processing activities.
PRT40	Captures Clinical Laboratory Improvement Amendments (CLIA) certification information and the specific procedures each laboratory is authorized to cover. Links the information for use in claims adjudication.
PRT41	Cross-references license and sanction information with other State or federal agencies.
PRT42	Identify, report, and take action regarding providers who are terminated, excluded, suspended or otherwise sanctioned by the State or CMS.
PRT43	Generates notices to providers of expiring Medicaid agreements and/or State licenses.
PRT44	Maintains multiple provider specific reimbursement rates with beginning and end dates, consistent with State policy including but not limited to 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.
PRT45	Maintain provider-based cost data for use in determination of case mix reimbursement rates.
PRT46	Accepts, validates, and processes transactions or user entries to update and maintain provider information.
PRT47	Maintain expiration dates for provider license and certification requirements.
PRT48	Provide the capability to add new provider types and taxonomies easily.
PRT49	Maintain a function to deactivate all provider records meeting specific State criteria (for example, sanctioned by the Medicare Program).
PRT50	Populate associated MMIS files with updated information when performing mass updates to the provider file. For example, information to the provider file will also update the ownership file and vice versa.
PRT51	Edit all entered data for presence, format, and consistency with other data in the update transaction and on the provider master file.
PRT52	Provide the ability to except duplicate SSNs and FEINs where appropriate.
PRT53	Maintain online access to all current and historical provider information with inquiry/update by variables such as provider name, phonetically similar name, partial name characters, NPI, provider type, taxonomy, SSN, FEIN, State, Tax ID, UPIN, CLIA number, town, county, zip code, HIPAA indicator, and EFT status and combinations of the above.
PRT54	Accept group provider numbers, and relate individual providers to their groups, as well as a group to its individual member providers. A single group provider record must be able to identify an unlimited number of individuals who are associated with the group.
PRT55	Maintain beginning and end effective dates for group providers and the individual providers associated with the groups.
PRT56	Identify multiple practice locations for a single provider and associate all relevant data items with the location, such as address and CLIA certification.
PRT57	Maintain provider's National Association of Board of Pharmacy (NABP) number including historic data with effective and end dates.
PRT58	Maintain the provider name on the provider master file as a single field, at least 45 characters long, except for mailing purposes.
PRT59	Accommodate and maintain the national Health Care Provider Taxonomy Code Set.
PRT60	Identify out of state providers with an indicator on the provider file and indicate that out of state hospitals are characterized by rural, urban, or teaching.
PRT61	Maintain effective beginning and end dates for any provider related information as designated by the State.
PRT62	Accept online, real-time updates of review or restriction indicators and dates on a

Provider Management – Technical Requirements	
	provider's record to assist DHSS in monitoring a provider's medical practice.
PRT63	Identify, including name, address, and telephone number, the entity through which a provider bills, if a billing service is used.
PRT64	Identify providers that use automated submittal of claim records, automated remittances, and/or EFT in claim records processing.
PRT65	Maintain multiple addresses for a provider, including but not limited to pay to, mail to, and service location(s).
PRT66	Accept and maintain the number of beds and licensed level of care, in addition to other State-specified data elements with maximum history and a minimum of 5 years of date-specific segments for LTC facilities that include both beginning and end dates.
PRT67	Maintain multiple provider types and taxonomies with enrollment status for each provider and with the flexibility to change provider type and taxonomy and enrollment status, and convert history records to reflect new provider type and taxonomy with enrollment status.
PRT68	Maintain the capability to identify agency or department programs based on provider taxonomy.
PRT69	Maintain specific codes for restricting the services for which providers may bill to those for which they have the proper certifications (for example, CLIA certification codes, dental anesthesia code).
PRT70	Display on-review data, and other special data (for example, lab certification and home health insurance data).
PRT71	Display information showing all rendering providers associated with a group, and all groups with whom a rendering provider is associated on one screen, for user defined time periods.
PRT72	Maintain multiple, provider-specific reimbursement rates by program, including fee-for-service, percentage of charges, per diems, case mix, rates based on licensed levels of care, volume purchase contracts or other cost containment initiatives, with beginning and ending effective dates for maximum history with a minimum of 5 years, with online, real-time update capability with password protection and an audit trail by operator ID.
PRT73	Maintain provider-specific rate files that accumulate facility-specific case mix, licensed level of care, or other rate data for user online inquiry.
PRT74	Maintain provider-specific rates by program, type of capitation, client program category, specific demographic classes, covered services, type of plan, and service area for any prepaid health plan or managed care providers and provide online user access.
PRT75	Perform mass updates to provider rate information at State direction based on both automated and manually entered updates.
PRT76	Accept retroactive rate adjustments to the provider file and track history of changes.
PRT77	Accept and maintain MCO numbers, relating individual network providers to any MCO they have a business relationship with as well as relating each MCO to the individual providers with whom they have a business relationship.
PRT78	Accept and maintain MCO client enrollment-related information including number of slots currently available, languages spoken, handicap access, and so forth.
PRT79	Provide the capability to identify a provider as a Managed Care Provider and maintain an inventory of clients enrolled.
PRT80	Maintain detail and summary-level accounts receivable and payable data in the provider file which is automatically updated after each claim records processing payment cycle by calendar, federal and State fiscal year-to-date totals.
PRT81	Generate a real-time full file of providers, in an agreed-upon State-approved format and media, to be provided to the State on an agreed upon periodic basis. Separate out fully enrolled, ordering and referring providers.

Provider Management – Technical Requirements	
PRT82	Utilize a Geographic Information System (GIS) to identify client populations, service utilization, and corresponding provider coverage areas by taxonomy or other criteria as specified by the State to support provider recruitment, enrollment, and participation.
PRT83	Provide for an online, updateable, free format, unlimited space comment or notes field or screen for provider information.
PRT84	At a minimum maintain the data set prescribed by Part 11 of the State Medicaid Manual.
PRT85	Maintain online access to all provider information for a minimum of 5 years, and number of years of history as determined by the DHSS.
PRT86	Maintain date-specific LTC data by provider (LTC facility) to include: a. Reimbursement rate and related effective dates b. Certification date c. Review date d. Number of licensed beds per Medicare and Medicaid e. IMD "at risk" indicator f. Case mix g. Type of facility (for example, NF, ICF-MR, IMD, Assisted Living, and Superskilled)
PRT87	Make available online copies of provider application enrollment documents and correspondence for viewing by authorized users.
PRT88	Provides user access to provider data and allows extraction of information. The extracts or reports could include such items as: a. The current status of providers' records b. An alphabetical provider listing c. A numeric provider listing d. A provider rate table listing e. An annual recertification notice f. A provider "group affiliation" listing g. A provider taxonomy listing h. A provider listing by category of service
PRT89	Create reports to meet all federal and State reporting requirements.
PRT90	Create reports related to provider correspondence as requested by the State.
PRT91	Create report showing status of provider enrollment activities and contracts in process by provider and in aggregate.
PRT92	Generate group mailings and provider labels based on selection parameters including provider type, category of service, taxonomy, town, county, zip code, and special program participation.
PRT93	Generate list of providers, as well as generation of provider letters as designated by the State, to be deactivated/purged due to inactivity or expiration of license, certification, or other documentation.
PRT94	Create online printable alphabetic and numeric provider listings that can be generated by all provider parameters in any combination including, but not limited to, program, provider type, category of service, taxonomy, town, county, zip code, and enrollment status.
PRT95	Create and maintain audit trail reports, including operator ID, of changes to provider file data including information such as, reports giving an unduplicated count of provider additions, re-enrollments, active and inactive by enrollment status, and taxonomy.
PRT96	Create reports of online information showing provider eligibility history.
PRT97	Create reports for provider cross-reference listings for SSN, FEIN, State Tax ID, CLIA, zip code, town and license numbers.
PRT98	Create report which displays growth in the number of active providers (including both billing and performing) by provider type and taxonomy over time.

Provider Management – Technical Requirements	
PRT99	Create report identifying providers who have changed practice arrangements and location (for example, from one group practice to another) by provider type.
PRT100	Create report showing all rendering providers associated with a group, and all groups with whom a rendering provider is associated, for user defined time periods.
PRT101	Generate Provider 1099 Statements, IRS 1099 tape, and associated payment reports.
PRT102	Create reports of online information required for institutional rate setting.
PRT103	Create reports of provider rate file data by provider, provider type, taxonomy, and other parameters.
PRT104	Create reports of provider accounts receivable and payable data, including claim records adjudicated but not yet paid.
PRT105	Create report of the number of beds in the facility and reimbursement rates for institutional providers.
PRT106	Create report of on-review data, and other special data (e.g., lab certification and home health insurance data).
PRT107	Generate demographic reports and maps from the GIS, for performing, billing, and/or enrolled provider, to assist in the provider recruitment process and provider relations.
PRT108	Report on CMS disclosure form information accessible to the State in paper and electronic format.
PRT109	Scan, index, and electronically store copies of all provider file maintenance updates and documentation.
PRT110	Support different notifications to be sent to providers, by program area or benefit plan (e.g., LTC, HCBS, and EPSDT).
PRT111	Tracks and controls the process of reconciliation of errors in transactions that are intended to update provider information.
PRT112	Maintains current and historical multiple address capabilities for providers.
PRT113	Maintain additional provider information as specified by the DHSS.
PRT114	Accept and maintain all relevant provider information, such as address, email address, phone numbers, fax numbers, hours of service, clients accepted, and CLIA certification number, for each provider location that services are provided.
PRT115	Support mailings to multiple provider addresses, as requested by the provider (e.g., Remittance Advice to one billing address and bulletins to service location).
PRT116	Maintains an audit trail of all updates to the provider data, for a time period specified by the State.
PRT117	Maintains providers' Drug Enforcement Administration (DEA) numbers.
PRT118	Updates and maintains financial data including current and prior year 1099 reported amounts.
PRT119	Calculate and maintain 1099 information by FEIN for providers and distribute 1099s to providers.
PRT120	Research and reconcile discrepancies of 1099 information.
PRT121	Accept IRS and State mismatch information on provider 1099 reporting and notify providers.
PRT122	Process or re-process provider 1099s withholdings accordingly after reconciling discrepancies.
PRT123	Provide the capability to calculate and maintain separate 1099 and associated payment data by FEIN for providers with changes of ownership.
PRT124	Maintains links from providers to other entities, such as Groups, Managed Care Organizations (MCO), Chains, Networks, Ownerships, and Partnerships.

Provider Management – Technical Requirements	
PRT125	Provides capability to do mass updates to provider information, based on flexible selection criteria.
PRT126	Maintains indicators to identify providers that are Fee-for-Service (FFS), Managed Care Organization (MCO) network only, and other State health care program participants.
PRT127	Maintains a flag for providers who are eligible to use Electronic Funds Transfer (EFT) and Electronic Claims Submission.
PRT128	Maintain record of billing agency name and pharmacy software vendor.
PRT129	Support an indicator for identifying what type of claims entry a provider utilizes.
PRT130	Provide an automated letter generation module. Letters generated must be reproducible, and be made available to all DHSS programs or the Contractor.
PRT131	Requires (when appropriate), captures, and maintains the 10-digit National Provider Identifier.
PRT132	The system must be NPI compliant.
PRT133	Accepts the NPI in all standard electronic transactions mandated under HIPAA.
PRT134	Interfaces with the National Plan and Provider Enumerator System (NPPES) to verify the National Provider Identifier of provider applicants once the Enumerator database is available.
PRT135	Does not allow atypical providers to be assigned numbers that duplicate any number assigned by the NPPES.
PRT136	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). Captures/crosswalks subpart NPIs used by Medicare (but not Medicaid) to facilitate COB claims processing.
PRT137	Develop, and make available free of charge, software, including updates, for providers to submit Electronic Claim Submission (ECS) online.
PRT138	Create a file for each MCO that lists all DMAP providers who are also MCO providers and have provided DHSS with the annual disclosure.
PRT139	Receive and store provider enrollment and summarized claim information in a batch format on a regular basis
PRT140	Provide the capability to maintain provider specific information such as contact information, email addresses
PRT141	Provide the capability for to send automated emails to providers based on various statuses of the application (for example – upon certain suspense scenarios, upon payment approval) using email addresses provided by the provider. (Provider - call center support)
PRT142	Maintain a repository of all Provider Incentive Payment activity (eligibility, payment, denial, appeals)
PRT143	Support functionality to enter notes and attach/upload documents to provider incentive payment records
PRT144	Allow a manual record lock and unlock (not allow changes) function to be performed by an SMHPO user with the appropriate role.
PRT145	Provide the ability to track a provider's appeal of eligibility and payment denial determinations
PRT146	Ensure the provider's application is complete, there are no provider exclusions/sanctions, and the NLR has verified that no duplicate payments have been made or the provider has any sanctions.
PRT147	Provide the ability to produce management level reports on provider participation, total incentive payments, and provider inactivity.

Provider Management – Technical Requirements	
PRT148	Make data available from the Provider Incentive Payment system for output in a common format to be used for data analysis (e.g., data warehouse, decision support)
PRT149	Collect and process information related to "Entities Promoting the Adoption of Electronic Health" from the Provider Incentive Payment system

C.5.1.3 Reference Data Maintenance

The primary function of the Reference Data Maintenance Business Area is to serve as the repository of data required for claims adjudication and pricing, Prior Authorization (PA) determination, and Coordination of Benefits (COB) processing. Reference data sets include procedure and pricing information updated annually through the Healthcare Common Procedure Coding System (HCPCS) and Resource-Based Relative Value Scale (RBRVS), International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes and International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) procedure codes, revenue codes, and provider/procedure-specific pricing data. Code sets within Reference Data Maintenance support a variety of management, ad hoc, and utilization reporting functions.

Some objectives of the Reference Business Area are:

1. Maintain data tables for edits, audits, drug data, and pricing codes
2. Provide online access to data tables
3. Receive and process updates

C.5.1.3.1 Contractor Business Responsibilities

Reference Data Management – Business Responsibilities	
RFB1	Operate the Reference Data Maintenance function of the DMES.
RFB2	Provide training to the State in the use of the Reference functions initially and on an ongoing basis.
RFB3	Contract with a drug updating service to update AWP and WAC drug prices at least weekly.
RFB4	Support all Reference Data Maintenance functions, files, and data elements necessary to meet the requirements in this RFP.
RFB5	Identify and recommend to the State changes to edits and audits to enhance processing and efficiency.
RFB6	Make recommendations on any area in which the Contractor thinks improvements can be made.
RFB7	Correctly apply updates to the Reference files within 2 business days of the update receipt.
RFB8	Provide listings of the Reference files to the State within 2 business days of receipt of the request.
RFB9	Support, update, and maintain all Reference User and System Manuals online.
RFB10	At a minimum, accept and maintain the data set prescribed by SMM 11330.
RFB11	Perform online and mass updates to the Reference files as specified by the State.

C.5.1.3.2 Contractor Technical Requirements

Reference Data Management – Technical Requirements	
RFT1	Maintains reasonable and customary charge information for Medicaid and Medicare to support claims processing: a. Reimbursement under the Medicaid program for other than outpatient drugs, Federally Qualified Health Center (FQHC), 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 charges submitted on provider claims for Medicaid payment. b. Support the capability to calculate drug prices based on AWP, WAC, FUL, DE-MAC or NADAC. The method of calculating a price must be either plus or minus a percent that extends to the hundredth decimal point (e.g., xx.xx%) 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.
RFT2	Maintain reasonable and customary charge information for Medicaid to support claims processing. Reimbursement for covered drug benefit products that are usually processed by either: a. Federal Upper Limit (FUL) or Maximum Allowable Cost (MAC) with some drugs; the State defined Estimated Acquisition Cost (EAC), plus a dispensing fee (and/or plus a provider specific dispensing fee; or b. The provider's usual and customary charge, paying the lesser of these fees
RFT3	Maintain all pricing files to ensure that claims are paid in accordance with DE Medicaid policy.
RFT4	Utilize, at no cost to the DHSS, HCPCS, ICD-9-CM, ICD-10, CPT, CDT, Revenue Code, and NDC (updated by the drug pricing vendor) coding systems for reference files, including the appropriate modifiers, etc., included in these standard code sets.
RFT5	Maintain the reference data required for DE Medicaid claims processing. The system should be flexible and configurable to adapt to changes in DE Medicaid and CMS policies and services and must allow for centralized control over data modifications.
RFT6	Provide for the capability to apply the following pricing methodologies, including, but not limited to: a. DRG with multiple base rates b. APC with multiple conversion factors c. Lab Panel vs. Automated Test Panel (ATP) d. All-inclusive rates e. Negotiated rates f. Geographic rates g. Waiver rates h. RBRVS with multiple conversion factors i. Provider specific j. Provider taxonomy k. Bundling/unbundling l. P4P m. Funding source n. Per diem o. Present on Admission (POA) p. Medicare Fees q. By Report r. Average Sales Price (ASP) s. 340B pricing

Reference Data Management – Technical Requirements	
	t. Dental Rates u. Modifier v. Place of service (facility vs. Non-facility) w. Percent of charges x. Procedure modifier combination y. Other methodologies, as specified by DHSS
RFT7	Accept updates from a variety of software programs, including but not limited to: Excel, Access, etc.
RFT8	Accommodate minimally weekly updates of NDC drug file.
RFT9	Process rate adjustments within a specified timeframe, as directed by the DHSS.
RFT10	Update all existing MACs quarterly as defined by DHSS and create new MACs as defined by DHSS.
RFT11	Supports Payment for Services by providing reference data, including procedure, diagnostic, revenue codes and formulary codes (42 CFR 447).
RFT12	Provide the capability to view and track any reference data changes at the field level online.
RFT13	Processes change transactions to procedure, diagnosis, revenue, and formulary codes and other data and responds to queries and report requests.
RFT14	Efficiently, and with limited manual intervention, support online update, revision, addition, or deletion of all reference codes annually (mass update) and/or periodically (individual), and allow off-line testing prior to system changes when necessary.
RFT15	Produce reports, as specified by the DHSS, of updates applied to the procedure, drug, revenue and diagnosis code files, including an error report to identify codes that did not update the appropriate procedure, drug, revenue and diagnoses code files.
RFT16	Archives all versions of reference information and update transactions.
RFT17	Support pricing during claims processing for all approved claim types and reimbursement methodologies maintaining history as specified by DHSS in global requirements.
RFT18	Accept and use effective and end dates for all reference codes and parameters to support maximal reference history as specified by DHSS in global requirements.
RFT19	Update transactions to the rate data and respond to queries and report requests.
RFT20	Provide that the update process for establishing or modifying any parameters, be streamlined and not require redundant entry of like data, while still allowing for differing methodologies.
RFT21	Provide an online notes system to track changes to the reference files.
RFT22	Retrieves, as needed, archived reference data for processing of outdated claims or for duplicate claims detection.
RFT23	Generates a summary of history file transfers.
RFT24	Maintains current and historical reference data used in claims processing.
RFT25	Create, support and maintain an online viewable cross-reference between HCPCS and ICD-10-CM procedure codes.
RFT26	Create, support and maintain an online viewable cross-reference between NDC groupings/definitions and HCPCS.
RFT27	Maintain procedure code files to the design and specification of DHSS.
RFT28	Maintain diagnosis code files to the design and specification of DHSS.
RFT29	Maintain revenue center code files to the design and specification of DHSS.
RFT30	Accommodate retroactive rate changes.
RFT31	Provide and maintain a complete history of previous fee schedules.
RFT32	Maintain online access and the ability to filter, sort and generate listings of all data

Reference Data Management – Technical Requirements	
	elements contained in the Reference Data Management module.
RFT33	Provide authorized users with online update access to reference data elements.
RFT34	Provide for role-based security to limit access to reference tables to DHSS specified staff.
RFT35	Maintain all history segments for all code sets (reference information) online for inquiry.
RFT36	Maintains an audit trail of all information changes, including errors in changes and suspended changes.
RFT37	Maintains revenue codes; provides online update and inquiry access, including: a. Coverage information b. Restrictions c. Service limitations d. Pricing data e. Effective dates for all items
RFT38	Maintains date sensitive parameters for all Reference Data Management data.
RFT39	Maintains current and historical coverage status and pricing information on legend drugs, Over The Counter (OTC) items, and injection codes.
RFT40	Supports code sets for the payment of Medicaid-covered non-health care services (e.g., waiver services).
RFT41	Maintain drug code files to the design and specification of DHSS.
RFT42	Maintains the trauma indicators to identify potential Third Party Liability (TPL) cases.
RFT43	Maintains diagnosis and procedure code narrative descriptions of each code contained in the files.
RFT44	All reference codes must have complete English language descriptions for all relevant parameters either on screen or easily accessible, for example, through a drop down menu.
RFT45	Updates all procedure, diagnosis and drug files if required prior to each payment cycle.
RFT46	Apply updates to all codes upon new releases (e.g., quarterly or annually) or as needed, or as directed by DHSS.
RFT47	Provide the online ability to place edit/audit criteria limits across claim types and provider taxonomy , on types of service by procedure code, revenue center code, diagnosis code and drug class, based on: a. Recipient age, sex, eligibility status, place of residence, medical coverage group b. Diagnosis c. Provider ID d. Provider taxonomy e. Place of service f. TPL g. Tooth and surface codes h. Once-in-a-lifetime procedures i. Lifetime maximum allowable services j. Floating fiscal year or calendar year period k. Months, calendar weeks or days periods
RFT48	Maintain and update the service frequency limitations for each procedure or for range of procedure codes contained on the edit.
RFT49	Maintain relationship edits on procedure and diagnosis codes.
RFT50	Place benefit limitations on types of service by procedure code, revenue code, and drug class, based on beneficiary age, beneficiary sex, diagnosis, provider taxonomy, and place of service. All segments must be date sensitive.
RFT51	Be able to limit the total number of services available (e.g., once-in-a-lifetime).

Reference Data Management – Technical Requirements	
RFT52	Provide online inquiry and update capability to monitor and control the disposition of claims.
RFT53	Contain and provide controlled access to a message field, which shall provide the text of the messages to be printed on the Remittance Advice (RA) for each error code.
RFT54	Allow a single provider to be paid based upon multiple pricing processes.
RFT55	Provide capability to allow multiple data elements to apply to all codes.
RFT56	Manage HIPAA-required external data sets (e.g., ICD-10, NDC).
RFT57	Comply with all federal regulatory requirements for HIPAA and CLIA.
RFT58	Maintain all data sets defined by the HIPAA Implementation Guides to support all transactions required under HIPAA Administrative Simplification Rule (e.g., Gender, Reason Code).
RFT59	Maintain and update taxonomy codes, which are published by the NUCC.
RFT60	Provide annual updates to HCPCS file including prices and clinical criteria such as gender, age and appropriate units

C.5.1.4 Claims Receipt

The Claims Receipt business area includes Claims Control and Claims Entry. The process encompasses the receipt and processing of electronic claims, receipt and processing of encounters, and data entry and capture of paper claims and supporting attachments. A unique control number is assigned to each claim, encounter, and attachment enabling tracking from receipt to final disposition.

Claims and their supporting attachments are accepted through online entry, Optical Character Recognition (OCR) / Imaging, and electronic submission. All electronic claims and encounter submissions must be in a HIPAA compliant format.

Some of the Delaware MMIS Claims Submission/Claims Entry Business Area objectives are:

1. Provide reliable data entry of paper claims and attachments.
2. Support timely claims resolution.
3. Maintain organized and retrievable imaging of paper claims.
4. Provide for efficient claims processing.
5. Maintain controls and balancing procedures.
6. Perform exception claims processing.

C.5.1.4.1 Contractor Business Responsibilities

Claims Receipt – Business Responsibilities	
CRB1	Perform data entry of all hard-copy claim records.
CRB2	Load electronically submitted claim records.
CRB3	Produce all claim records entry statistics reports and deliver to the State.
CRB4	Enter all hard-copy claim records within 1 business day of receipt.
CRB5	Maintain data entry error rates of below 2%.
CRB6	Load electronically submitted claim records within one business day of receipt by the Contractor.
CRB7	Enter claim forms into the DMES as mandated by CMS or utilized by the State in hard

Claims Receipt – Business Responsibilities	
	copy formats including: CMS-1500, UB-04, Pharmacy claim form that adheres to National Council for Prescription Drug Programs (NCPDP) standards, and ADA dental claim form. Claim forms as mandated by CMS or utilized by the State in electronic formats including: ASC X12 Ver. 5010, Institutional, Dental and Professional NCPDP. Ver. D.0 (Interactive); Ver. 1.2 (Batch).
CRB8	Deliver and pick up mail each business day and at the request of the State.
CRB9	Establish controls to ensure no mail, claim records, tapes, diskettes, cash, or checks are misplaced after receipt by the Contractor per HIPAA regulations.
CRB10	Pre-screen hard-copy claim records before entering into the system, and return those not meeting certain criteria (for example, no provider number) to providers within 2 business day; log returned claim records daily.
CRB11	Establish balancing processes to ensure control within the DMES processing cycles.
CRB12	Reconcile all claim records (hard-copy and Electronic Claim Submission [ECS]) entered into the system to batch processing cycle input and output figures.
CRB13	Produce online and hard-copy balancing and control reports according to State specifications.
CRB14	Prepare and control all incoming and outgoing Delaware Medical Assistance Program mail, to ensure claim records and other correspondence are picked up and delivered at/to any site designated by the State, through the most effective and efficient means available.
CRB15	Image and assign Individual Control Numbers for every claim and attachment within 1 business day of receipt.
CRB16	Retain hard-copy documents and claim records, and adjustments in accordance with the Delaware Division of Historical and Cultural Affairs, Bureau of Archives and Records Management Standards and prepare them for archiving according to the approved schedule and procedure.
CRB17	Provide assistance to the State in researching discrepancies.
CRB18	Perform corrective actions as directed by the State.
CRB19	Make recommendations for improvements when possible.
CRB20	Respond to requests for electronic and paper reports and records for both providers and clients timely and accurately.
CRB21	Load and process Vaccines for Children (VFC) files to pay the administration fees.
CRB22	Maintain and provide the State with hard-copy original claim records, adjustments, attachments, non-claim transaction documents, and all ECS billings for all transactions processed, as requested by the State.
CRB23	Maintain and produce claim records inventory reports after each processing cycle.

C.5.1.4.2 Contractor Technical Requirements

Claims Receipt – Technical Requirements	
CRT1	Captures accurately all input into the system at the earliest possible time.
CRT2	Assigns each claim a unique identifier upon its entering the system.
CRT3	Accepts and uses the common hospital paper billing form developed by the National Uniform Billing Committee (NUBC), for non-electronic claims.
CRT4	Accepts and uses the common non-institutional paper claim form developed by the National Uniform Claim Committee (NUCC), for non-electronic claims.
CRT5	Accepts and uses the common dental paper billing form developed by the American Dental Association (ADA), for non-electronic claims.
CRT6	Controls, tracks, and reconciles captured claims to validate that all claims received are

Claims Receipt – Technical Requirements	
	processed.
CRT7	Provides the ability to identify claims input for control and balancing (hardcopy and electronic media).
CRT8	Provide the capability for automatic RTP (return to Provider) letter generation and maintain RTP transaction history
CRT9	Inventory management reports by claim record processing location indicating program and claim type, as well as, system age and processing location age (organized into at least eight time ranges).
CRT10	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, pre-editing, and key verification for: a. Provider number b. NPI Number c. Taxonomy d. Client ID number e. Procedure codes f. Diagnosis codes g. Other key fields as required
CRT11	Maintain extract files that contain key elements of support files to verify the validity of entered and scanned claim record information and the accuracy of keying. Extract files will be updated with current information during the same cycle in which update transactions are applied to file records.
CRT12	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.
CRT13	Screens and captures electronic images, date-stamps, assigns unique control numbers and batches hardcopy claim forms and attachments, adjustment/void forms, and other documents as required.
CRT14	Logs each batch into an automated batch control system to ensure an accurate trail from receipt through data entry to final disposition. Claim control can be either at the batch or document level. All claims must be tracked and controlled.
CRT15	Provides the ability to identify claim entry statistics to assess performance compliance.
CRT16	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.
CRT17	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.
CRT18	Provide the ability to tie the electronic claim to all related paper claim images, attachments, and adjustments that are submitted for the claim.
CRT19	Receive and process electronic attachments, and apply them to one or more claims.
CRT20	Provide the capability to accept attachments to any transactions (claim, PA, eligibility), and apply an attachment indicator in the MMIS and DSS.
CRT21	Provides and maintains a Web portal for providers to directly and efficiently enter claims/encounters including adjustments and voids. The web portal should generate claim output in currently applicable standard formats (X12) to the MMIS for processing.
CRT22	Allow for resubmission of rejected and denied claims on a self-service basis through the web portal.
CRT23	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 production system data.

Claims Receipt – Technical Requirements	
CRT24	Identifies any incomplete claim batches that fail to balance to control counts.
CRT25	Provide a return transmission that verifies the number of claims received and accepted.
CRT26	Maintain EDI transmission logs of all transactions (successful or failed, etc.)
CRT27	Provides and maintains the capability to process standard financial transactions including recoupments and payouts which cover more than one claim/service.
CRT28	Edit to prevent duplicate entry of electronic media claim records.
CRT29	Provide processes and data to meet, at a minimum, the requirements in Part 11 of the State Medicaid Manual.
CRT30	Accept adjustments in both hard-copy and electronic formats.
CRT31	Support NPI and atypical provider numbers as the primary provider ID for all claim submission
CRT32	Receive cross-over claims via electronic format (from the COBC and providers), by paper, or web portal entry.
CRT33	Accepts, records, stores, and retrieves documents (in freeform or in HIPAA attachment formatting) submitted with or in reference to claim submission activity, such as: a. Operative reports b. Occupational, physical, and speech therapy reports c. Durable Medical Equipment (DME) serial number, cost, and warranty data d. Manufacturer's tracking data for implants e. Waivers and demonstration specific requirements
CRT34	Receives claim attachments associated with electronic media or paper claims and auto-archives or forwards to appropriate operational area for processing.
CRT35	Provide a solution to automatically link attachments to claims (e.g., utilizing barcodes)
CRT36	Accepts Medicare and Medicare Advantage Plan crossover claims (for Medicare coinsurance and deductible) or Medicare Explanation of Benefits (EOB) claims attachments.
CRT37	Accepts prior authorization attachments such as: a. Surgical/anesthesia reports b. Medical records c. X-rays/images d. Orthodontic study models e. LTC prior Authorization f. Certain prescription drugs as required g. Other items required by State or federal rules
CRT38	Accepts other claim related inputs to the MMIS, including but not limited to: a. Sterilization, abortion, and hysterectomy consent forms b. Manual or automated medical expenditure transactions which have been processed outside of the MMIS (e.g., spend-down) c. Non claim-specific financial transactions such as fraud and abuse settlements, insurance recoveries, and cash receipts d. Electronic cost reports e. Disproportionate share reports f. Drug rebate g. Any other inputs required for services under the State's approved plan
CRT39	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: a. Retail pharmacy drug claims (NCPDP) b. Dental health care claims (X12N 837D)

Claims Receipt – Technical Requirements	
	c. Professional health care claims (X12N 837P) d. Institutional health care claims (X12N 837I) e. Coordination of benefits data, when applicable f. Future claims attachments required under HIPAA g. Including X12, NCPDP, and support for ICD-10
CRT40	Receive standardized encounters in HIPAA compliant formats.
CRT41	Provides secure, HIPAA compliant software and documentation for use by providers to submit electronic claims.
CRT42	Accept batch 837 claims, rejecting only individual bad claims and accepting all others.
CRT43	Provide the ability to reject claims based on an individual claim basis, utilizing front-end edits, as specified by the DHSS (e.g., claims that fail front-editing rules will not get into the system), and maintain a log of all rejected claims.
CRT44	Provide the capability to capture and process, at a minimum, the number of claim lines specified in the HIPAA named transactions.

C.5.1.5 Claims Processing

The Claims Processing and adjudication function validates claims submitted, determines the allowed reimbursement amount and the final disposition. Managed care encounters are also processed by the claims processing function however no payment is made for encounters. Claims failing validation are suspended for correction or are denied. Claims requiring review are suspended for error resolution or manual review.

Single claim and encounter adjustments are entered online. Mass adjustments may be both entered online and system generated. All adjustments are processed through the claims processing function.

Operational tasks include a system to balance claims, to know the location and status of every claim record and ensure that every claim received has been properly adjudicated. All EDI and automated interface transactions are handled under a variety of connectivity methods and computer platforms.

Some of the Claims Processing Business Area objectives are:

1. Efficiently process and pay claims to providers
2. Resolve suspended claims in a timely manner
3. Correct and adjudicate claims with errors (error resolution)
4. Provide the State with hard-copy original claim records, adjustments, and any attachments
5. Process claims following State policy through edits and audits
6. Retain for State review all ECS billings for all transactions processed

C.5.1.5.1 Contractor Business Responsibilities

Claims Processing – Business Responsibilities	
CRB24	Retain adjustments for six months in accordance with the Delaware Division of Historical and Cultural Affairs, Bureau of Archives and Records Management Standards and then destroy them after that time period has passed.

Claims Processing – Business Responsibilities	
CRB25	Perform McKesson updates to ClaimCheck® Knowledge Base or other similar product.
CRB26	Perform McKesson updates to ClaimCheck® software or other similar product.
CRB27	Provide ongoing policy updates and ClaimCheck® edit/audit customization or other similar product.
CRB28	Perform transfer of ClaimCheck® or other similar product, knowledge database/customization from the PC to the testing and production systems as needed.
CRB29	Provide customization reports and audit trails from ClaimCheck® Knowledge database or other similar product.
CRB30	Maintain new EOB codes and new EOB-to-HIPAA claim adjustment mappings for new reasons for claim detail denial.
CRB31	Train State staff on the use of McKesson ClaimCheck® or other similar product and effects resulting from use of the ClaimCheck® or other similar product when requested by the State.
CRB32	Maintain materials for education and training of Providers on ClaimCheck® software of other similar product.
CRB33	Maintain the educational plan to inform providers on the use of ClaimCheck® or other similar product, which will include communication with providers through the following venues: a. Provider association meetings b. Email notifications c. RA banners d. Web postings e. Coordination with the Medical Society of Delaware and other groups to share information f. Phone greeting message g. Mass mailing notification (using Provider Bulletin mailing list)
CRB34	Update and maintain all documentation affected by the implementation of McKesson ClaimCheck or other similar product and get State approval. All system documentation and manuals include, but not limited to: a. General Policy Manual b. CMS-1500 Billing Manual c. UB-04 Billing Manual d. Pharmacy Billing Manual e. Dental Billing Manual f. Edit Manual g. Audit Manual h. Pricing Manual i. Tables Manual
CRB35	Maintain an adequately staffed claims adjustment unit to handle voids, credits, and debits in a timely manner.
CRB36	Notify DHSS in writing immediately upon discovery of any overpayments, duplicate payments, or incorrect payments regardless of cause
CRB37	Adjudicate all claims within 12 months of receipt, except for those exempted from this requirement by federal timely claims processing regulations.
CRB38	Create a digital image for viewing every claim and attachment within 1 business day of receipt.
CRB39	Claim turnaround time - 99% of all claims including paper and electronic claims paid or denied within 30 calendar days of receipt unless specified differently by DHSS.

Claims Processing – Business Responsibilities	
CRB40	Claims Throughput: 100% of claims will be paid, denied, or suspended during the reporting period.
CRB41	Process all nursing home and all waiver claims in the next claim cycle after receipt.
CRB42	Process all provider-initiated adjustments to payment or denial within 45 calendar days of receipt.
CRB43	Mail all notifications of payment denial within 30 calendar days of receipt.
CRB44	Mail all gross adjustment letters within 24 hours of the claims processing cycle.
CRB45	Meet all statements that the American Recovery and Reinvestment Act of 2009 (ARRA) Prompt Pay provision performance requirements contain.
CRB46	Complete and deliver to DHSS by the last day of January of each year a report on Controls Placed in Operation and Tests of Operating Effectiveness audit performed under Statement on Standards for Attestation Engagements (SSAE) No. 16, and Assurance Reports on Controls at a Service Organization (ISAE) 3402 Reporting on Controls at a Service Organization.
CRB47	Provide the following minimum number of file update and claims processing cycles under this Contract following data input and data entry keying accuracy standards of 97%: a. Three edit/audit cycles per day b. Three pricing cycles per day c. One payment cycle per week d. All external file updates applied within a week of receipt
CRB48	Claim volume: POSSIBILITIES: a. 200,000 claims a week and 50,000 a day to accommodate Integrated LTC b. Develop a formula/methodology for estimating volume and require the FA to periodically reassess and maintain their capacity

C.5.1.5.2 Contractor Technical Requirements

Claims Processing – Technical Requirements	
CAT1	Tracks all claims within the processing period – paid, pending or denied.
CAT2	Pend claims with exceptions/errors and route 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.
CAT3	Support routing of claims for State review and resolution.
CAT4	Provide an easily updateable and configurable means to add, delete and change processing locations and their descriptions. The system should support up to 999 processing locations.
CAT5	Display online pending claim records in a particular processing location. These must be able to be sorted by processing location age, system age, edit/audit, client ID and provider ID (both performing and group).
CAT6	Allow online correction to claim records with data entry errors.
CAT7	Provide the ability online to retrieve and view the claim record.
CAT8	Provide for an online, updateable, free format, unlimited space comment or notes field or screen for claim specific information.
CAT9	Inquiry screens must include pertinent header and detail claim data and status.
CAT10	Provide access to claim records (pending or adjudicated) through windowing, split screen, or other electronic techniques.
CAT11	Provide the ability to view supporting reference file data (e.g., procedure, diagnosis, Provider, Client, and prior authorization data) from the claims/encounters inquiry and claims/encounters update screens.

Claims Processing – Technical Requirements	
CAT12	Maintain all pending claim records in a pending status until adjudicated.
CAT13	Completely re-edit/audit claim records when manually or systematically reprocessed/recycled.
CAT14	Provide the ability to easily and immediately transfer pended claim records to another processing location.
CAT15	Capability to recycle all pending claims or targeted claim records through the entire edit/audit process upon DHSS approved schedule, and upon request.
CAT16	Provide for online inquiry into edit/audit status of claim records.
CAT17	Support different edit disposition codes based on funding source code.
CAT18	Provide roles-based security for staff making changes to edit/audit and disposition tables.
CAT19	Provide an online audit trail to identify who made changes to edits/audits and disposition tables.
CAT20	Provide the capability to bypass claim/encounter edits and audits online based on criteria defined by DHSS (e.g., category of service, Provider taxonomy, type of bill, aid category, program, procedure code, revenue code, modifier, diagnosis code, claim/encounter type, county, and Prior Authorization).
CAT21	Verifies that pending transactions have valid error/exception codes.
CAT22	Provide the ability to designate and change the Begin and End date for each edit/audit and to specify date of service or date of submission.
CAT23	Provide the ability to enter online notes concerning changes to edits/audits and disposition tables.
CAT24	Edit each claim record as completely as possible during an edit/audit cycle rather than ceasing the process when a failure is encountered so as to not require multiple resubmissions of claim records.
CAT25	Tracks claims flagged for investigative follow-up because of third party discrepancies.
CAT26	Generates audit trails for all claims, maintains audit trail history.
CAT27	Identify and track all edits/audits posted to the claim record from suspense through adjudication including edits and audits overridden by Prior Authorization.
CAT28	Maintain audit trail of all edits, audits, and locations posted to the claim per claim header and detail
CAT29	Generate and maintain audit trails for all claims activity. Provide an audit trail, with the ability to be retrieved, of all edit/audit changes. This audit trail, at a minimum, must include: a. Data prior to change b. The ID of user making change c. The time of change d. Source of the change
CAT30	Verifies that all claims for services approved or disallowed are properly flagged as paid or denied.
CAT31	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.)
CAT32	Provides prompt response to inquiries 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 (ASC X12N 276/277, web portal, IVR) required by 45 CFR Part 162 using formats and exposed services approved by the System Integrator.
CAT33	Provides claims/encounters history for use by Program Management and Program Integrity.

Claims Processing – Technical Requirements	
CAT34	Assigns claim status (i.e., approved, denied, and pending) based on the State's criteria.
CAT35	Update claim record history with the disposition at both header and detail level (including EOB, resolution status, adjudication date) for adjudicated claim records from the previous payment processing cycle.
CAT36	Verifies that claim correction activities have entered only valid override code(s) or manual prices.
CAT37	Allow authorized users to deny/override the system edits to pay or deny a claim per business rules. Track and report all overrides and denials by user on a daily basis.
CAT38	Identifies and hierarchically assigns status and disposition of claims (pend or deny) that fail edits (based on the edit disposition record).
CAT39	Support line-level approval and denial of claim lines.
CAT40	Support the ability to deny a claim at the header or detail level regardless of edit and audit presence and allow for the manual entry of an EOB code.
CAT41	Identify the disposition of claim records (e.g., pending, deny, pay, test, inactivate, and report) that fail edits/audits and provide the ability to easily set and update the disposition, processing location and EOB based on parameters such as origin of claim record, claim type, provider taxonomy, client eligibility, program, or individual provider number.
CAT42	Identifies and tracks all edits and audits posted to the claim in a processing period.
CAT43	Provide the online capability to establish a prioritization of edits, as defined by DHSS, so that major edits process first.
CAT44	Provides and maintains, for each error code, a resolution code, an override, force or deny indicator, user ID, and the date that the error was resolved, forced, or denied.
CAT45	Maintain claim record history for audit processing where the audit criteria covers a period longer than 5 years (such as once-in-a-lifetime procedures).
CAT46	Verifies that all fields defined as numeric contain only numeric data.
CAT47	Verifies that all fields defined as alphabetic contain only alphabetic data.
CAT48	Verifies that all dates are valid and reasonable.
CAT49	Edit claim records for dates of service that span parameters such as provider or State fiscal year, client aid category, and program begin/end date.
CAT50	Verifies that all data items which can be obtained by mathematical manipulation of other data items, agree with the results of that manipulation.
CAT51	Verifies that all coded data items consist of valid codes (e.g., procedure codes, diagnosis codes, revenue codes, service codes) are within the valid code set HIPAA Transactions and Code Sets (TCS) and are covered by State policy
CAT52	Adjudicate claims based on HIPAA standard code sets in effect on the date of service.
CAT53	Support claim adjudication based on HIPAA procedure modifiers in effect on the date of service
CAT54	Verifies that any data item that contains self-checking digits (e.g., Client I.D. Number) passes the specified check-digit test.
CAT55	Verifies that numeric items with definitive upper and/or lower bounds are within the proper range.
CAT56	Verifies that required data items are present and retained) including all data needed for State or federal reporting requirements (see SMM 11375).
CAT57	Retain all data elements on all claims (e.g., ASC X12 837I/P/D, NCPDP, CMS 1500, ADA dental 2006 and UB04 paper claims), even if not currently used for adjudication.
CAT58	Verifies that the date of service is within the allowable time frame for payment.
CAT59	Verifies that the procedure is consistent with the diagnosis.
CAT60	Verifies that the procedure is consistent with the NDC drug code, including the

Claims Processing – Technical Requirements	
	functionality of Drug Utilization Review on drug defined procedure codes.
CAT61	Verifies that the procedure is consistent with the client's age.
CAT62	Verifies that the procedure is consistent with the client's sex.
CAT63	Verifies that the procedure is consistent with the place of service.
CAT64	Verifies that the procedure is consistent with the provider's category of service and taxonomy.
CAT65	Flags and routes for manual review claims with individual procedures and combinations of procedures which require manual pricing in accordance with State parameters.
CAT66	Price compound drugs by applying the DHSS defined methodology for ingredients and applying a variable dispensing fee as defined by the program.
CAT67	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: a. Possible incorrect procedure b. Possible incorrect billed amount c. When too high, possible need for individual consideration
CAT68	Verifies that the claim is not a duplicate of a previously adjudicated claim (including a prior one in the current processing period and adjudication cycle).
CAT69	Perform automated exact duplicate, suspect duplicate, limitation and relationship audits on all claim records using history claim records, pended claim records, and same cycle claim records across provider and claim types.
CAT70	Audit for suspect duplicate claim records based on a cross-reference of group and performing provider, multiple provider locations, and other criteria specified by the State.
CAT71	Refine duplicate audit criteria to achieve a cost effective balance between duplicate suspense rates and duplicate payments, such as duplicate auditing at the GCN level for drug claims.
CAT72	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 client.
CAT73	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 client unless the additional services are appropriate for the same date of service.
CAT74	Utilizes data elements and algorithms to compute claim reimbursement for claims that is consistent with 42 CFR 447.
CAT75	Provide the capability to pay different rates for the same service, based on the program, benefit plan, or provider, as specified by DHSS.
CAT76	Flags for review claims from a single provider for multiple visits on the same day to a single client.
CAT77	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.
CAT78	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.
CAT79	Support claim audits based on rolling time periods and fixed time periods.
CAT80	Has the capability to pay claims per capita, from encounter data or fee-for-service.
CAT81	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).
CAT82	Provide the ability to categorize out-of-state hospitals as rural, urban, or teaching and then price the same as the designated in-state rural, urban, or teaching hospital.

Claims Processing – Technical Requirements	
CAT83	Records and edits that all required attachments, per the reference records or edits, have been received and maintained for audit purposes.
CAT84	Support electronic attachments during the adjudication process.
CAT85	Prices claims according to pricing data and reimbursement methodologies applicable on the date(s) of service on the claim.
CAT86	Provide the ability to process and price encounter claims as specified by DHSS.
CAT87	Claims payment shall be based on benefit plan specifications and may be limited to certain diagnosis codes and CPT codes.
CAT88	Support the immediate use of changes to the pricing methodology and pricing rules upon entry into the system.
CAT89	Deducts Third Party Liability (TPL) paid amounts and Medicare paid amounts, as defined in the State Plan, when determining provider payment.
CAT90	Edit all claim records for TPL (including Medicare) based on parameter such as procedure codes, drug codes, diagnosis codes, categories of service, the TPL insurance company coverage matrix, or a combination of data from these sources.
CAT91	Deducts client co-payment amounts, as appropriate, when determining provider payment.
CAT92	Provide the ability to accept and deduct various forms of client cost-sharing such as patient payment and copayment on applicable claim records.
CAT93	Establish a monthly co-payment limit at the individual level. Claims that are submitted after the client's maximum has been reached will be paid appropriately based on the limits.
CAT94	Applies Medicare coinsurance or deductible for crossover claims, depending on State policy, at the lower of the Medicaid or Medicare allowed amount when determining provider payment.
CAT95	Provide the ability to selectively re-price Part A or B Medicare claim records based on parameters such as the provider taxonomy and client aid category. For services that are covered and re-priced, the amount paid is limited to either the Medicaid rate for the service minus the actual Medicare payment or the deductible and/or coinsurance, whichever is less. Zero payment is made when the Medicare payment is equal to or higher than the Medicaid rate. For services that are not covered by the DMAP but are covered by Medicare or are not selected for re-pricing, the provider is reimbursed the full deductible and/or coinsurance amount identified by Medicare. Medicare re-pricing must be able to be done at the detail or header.
CAT96	Process Medicare crossover and Medicare Advantage plan claims and Medicare Explanation of Benefits (EOB) claims and attachments.
CAT97	Prices services billed with procedure codes with multiple modifiers.
CAT98	Edits claims for consistency and payment limitations using the Medicare Correct Coding Initiative or similar editing criteria, based upon the State Plan.
CAT99	Audit for individual HCPCS procedure codes billed separately (unbundling) when there is one HCPCS procedure code describing the entire group. The audit shall only be set when every individual HCPCS procedure code in the group is billed.
CAT100	Prices claims according to the policies of the program the Client is enrolled in at the time of service and edits for concurrent program enrollment.
CAT101	Contain a benefit plan hierarchy that pays claims according to DHSS specified order.
CAT102	Provide the ability to support and process claims according to individual program policies.
CAT103	Provide the ability to manually price both inpatient and outpatient claim records.
CAT104	Provides and maintains test claim processing capabilities including testing with providers.
CAT105	Contain a mechanism where claims may be tested through the entire system, to be used

Claims Processing – Technical Requirements	
	for systems changes, and system verification (including complete adjudication cycle).
CAT106	Produce each output of Integrated Test Facility (ITF), including files, reports, tapes, images, etc., separate from the corresponding routine MMIS output, and identify as a test output.
CAT107	Support the selection of pended and paid claims from the production files to create or append to test files. Provide access to inquire and update claims by authorized DHSS users.
CAT108	Process a sample of claims through the ITF weekly. The sample claims will test each edit in the production MMIS. The results of this test must be verified for correctness, and maintained by the Contractor for the duration of the Contract period.
CAT109	Provide authorized DHSS users, as specified by the DHSS, inquiry access to a fully functional test system that contains all parts of the MMIS source code. There must be two separate distinct environments, that mirror the production environment, in which testing can be done. One environment can be used to verify production changes; the other environment will be used for DHSS to test various additional scenarios.
CAT110	Support online testing of a claim, including Pharmacy POS through the system, and return processing and error messages to the submitter as they would appear in production.
CAT111	Provide a test environment that enables modeling of mass void and replace impacts, through complete adjudication, before running the void and replacements in a production cycle.
CAT112	Provide the capability to refresh the ITF with a copy of current production data files on a schedule agreed upon with DHSS.
CAT113	Support the use of a business rules engine separate from the core system.
CAT114	Provide the capability to configure edits and audits in a rules engine.
CAT115	Support the exporting of business rules in human readable format for exporting to HHS.
CAT116	Implement online, real-time claims adjudication in addition to traditional batch processing.
CAT117	Support processing of claims with at a minimum, the number of claim lines specified in the HIPAA transactions.
CAT118	Generate MMIS managed care capitated payment requests.
CAT119	Provide the capability to generate and price MMIS negotiated capitated payments.
CAT120	Provide processes and data to meet, at a minimum, the requirements of Part 11 of the State Medicaid Manual.
CAT121	Ability to price CMS–1500, ADA Dental 2006, pharmacy, and UB-04 (non inpatient hospital) claim records using any combination of HCPCS procedure codes, CDT procedure codes, revenue codes, type of service, and modifiers using the following pricing mechanisms: a. Manual pricing b. Rate on file in accordance with DMAP policy c. Rate on file or billed amount, whichever is less d. Percentage of rate on file e. Percentage of rate on file or billed amount, whichever is less f. Percentage of charges g. Percentage of charges up to a dollar cap amount h. Percentage of Medicare Rate i. Anesthesia formula or billed amount, whichever is less j. FQHC Encounter rate pricing with separate rate for medical and dental services k. Pricing of ambulatory surgical center claim records and any other mechanism specified by the State. 1. All of the above mechanisms must be able to be flexibly applied according to

Claims Processing – Technical Requirements	
	the following: a. Geographic area by county or zip code of provider or client b. Individual provider number c. Individual client identification number d. Client age, sex, or aid category e. Provider taxonomy f. Program such as EPSDT or Part C g. Standard for all providers h. Any other configuration specified by the State
CAT122	Provide for inpatient hospital pricing methodologies including: a. Flat rate per discharge by revenue code with outlier when the claim billed amount exceeds a specified threshold b. Per diem c. Percentage of charge d. Diagnosis Related Groups (DRG) e. Other method specified by the State
CAT123	Provide the ability to apply all outpatient hospital pricing methodologies on one outpatient hospital UB-04 claim record as well as the ability to "bundle" certain revenue codes into the flat rate per revenue code. Outpatient hospital pricing methodologies include, but are not limited to: a. Flat rate per revenue code, procedure code, and diagnosis code b. Rate per revenue code, type of service, and procedure code, or billed amount whichever is less **c.** Percentage of charge per revenue code
CAT124	Provide the ability to handle risk adjusted payments, risk sharing, stop loss, and financial incentives and sanctions for Managed Care.
CAT125	Provide the ability to prorate capitated payments for Managed Care and Managed LTC to allow accurate reimbursement for various time periods such as month, partial month, day, or quarter.
CAT126	Ability to price pharmacy claim records as specified by DHSS.
CAT127	Provide the ability to price VFC claim records with a calculated payment amount but to authorize a zero payment amount to the provider when the client is enrolled in an MCO on the date of service.
CAT128	Provide the capability to easily set and change the disposition of edits/audits to pend to a specific processing location.
CAT129	Provide the capability to easily change whether a particular edit/audit can be overridden.
CAT130	Edit/audit and pend each line on a multi-line claim record independently. A multi-line claim record shall be released to adjudication only after all details have completed the edit/audit process.
CAT131	Edit each data element on the claim record for required presence, format, consistency, reasonableness, and allowable values.
CAT132	Edit for limits on the number of units billed and the minimum and maximum number of days in the required billing period for each claim record detail for revenue codes and procedure codes.
CAT133	Have the ability to selectively edit/audit encounters.
CAT134	Provide online, real-time, claims resolution, including data correction, edit/audit override and denial capabilities for all claim types.
CAT135	Provide the ability to organize and retrieve pended online claim records by any

Claims Processing – Technical Requirements	
	combination of parameters such as processing location, client ID, provider ID, location age, system age, and edit/audit (header or detail). Provide the capability to then resolve the retrieved records.
CAT136	Provide the capability to apply a global resolution (override, deny) to a selected group of pended online claim records. For example, deny all claim records from a given provider for a particular procedure code using a specific EOB.
CAT137	Provide the ability to data correct or change previous decisions on pended claim records at any point prior to finalized status.
CAT138	Provide the capability of entering multiple EOB codes for a claim record (at both the header and the detail) which appear on the RA.
CAT139	Provide a flexible individual adjustment process that can be controlled by various parameters or selection criteria (including procedure code and NPI) for all claim types. These adjustment processes must be available online and via paper.
CAT140	Maintain edit/audit history on all iterations of adjusted claims.
CAT141	Accept and process electronically submitted adjustments and voids including Medicare cross-over claims from the COBC and directly from the Provider.
CAT142	Provide the ability to allow adjustments to zero paid claim records.
CAT143	System shall support the adjusting of both paid and denied claim/encounters.
CAT144	Maintain control to prevent multiple adjustments to a single claim record.
CAT145	Apply successive adjustments to the most current version of the claim.
CAT146	Provide that an adjusted claim carry with it its history including the following linkages, the original claim with all of the original information including, but not limited to, the original paid amount, the adjusted amount, the full amount gross calculated, and the net amount calculated.
CAT147	Maintain complete, online printable, audit trails of adjustment processing activities on the claims history files including the operator ID initiating the adjustment.
CAT148	Update provider payment history and client claims history with all appropriate financial records and reflect adjustments in subsequent reporting, including claim-specific and non claim-specific recoveries.
CAT149	Maintain a process to identify the claim/encounter to be adjusted, display it on a screen, and change the fields to be adjusted with minimal entry of new data, including claim/encounter records beyond the 5-year active history maintained online.
CAT150	Provide the ability for the provider community to submit written remarks on both paper and electronic adjustments. The MMIS must capture and store these remarks.
CAT151	Support an automated managed care adjustment process for encounter records.
CAT152	Provide the methodology to complete the claim adjustment process in the same payment cycle.
CAT153	Edit, price, and audit each adjustment, including checking for duplication against other regular and adjustment claim records, in history and in process.
CAT154	Maintain an adjustment reason code which indicates who initiated the adjustment, the reason for the adjustment, and the disposition of the claim (additional payment, recovery, history only, etc.) for use in reporting the adjustment.
CAT155	Provide the capability to allow online changes to the adjustment claim record to reflect corrections or changes to information during the claim correction (suspense resolution) process.
CAT156	Provide the ability to automatically adjust claim/encounters based on eligibility changes as specified by DHSS.

Claims Processing – Technical Requirements	
CAT157	Follow standard accounting principles and issue standard accounting balance and control reports. The results of adjusted claim records shall be reflected throughout the MMIS: claims history, PA units used, IRS 1099 tax form, and all other reports and all online data affected by an adjustment shall reflect the results of an adjustment.
CAT158	Supports the ability to recoup advanced payments and other funds due from Providers according to DHSS policy.
CAT159	Automated support of the (42 CFR 433 subpart F) CMS 60-day rule on recoupment.
CAT160	Provide the ability to adjust capitation payments based on client eligibility or enrollment status or other changes that would affect the capitation payment rate.
CAT161	Create a skeleton claim from archived history if the claim to be adjusted has been purged from online history.
CAT162	Provide a flexible mass adjustment/void process that can be controlled by various parameters or selection criteria including procedure code, edit code, and provider-for all claim types.
CAT163	Provide the ability to perform mass adjustments/voids upon request by authorized users.
CAT164	Provide an automated mass-adjustment function to re-price claims/encounters for retroactive pricing changes, client or Provider eligibility changes, and other changes necessitating reprocessing of multiple claim/encounters, as specified by DHSS.
CAT165	Maintain an online mass-adjustment function to select and/or adjust claim/capitation records with billed amounts that would be less than allowed/paid amounts at the end of the adjustment process.
CAT166	Provide the ability to import a list/file of claim numbers for mass adjustment.
CAT167	Have a mass adjustment release/recycle process capable of releasing claims by date, batch, provider, client, and other values determined by DHSS.
CAT168	Provide the ability to online retrieve adjustment claim records using multiple criteria or purpose of the adjustment at the claim level, including rate change, SUR action, medical policy request, provider request, State level request, and the like.
CAT169	Maintain an online mass-adjustment function to re-price claim records, within the same adjudication cycle, for retroactive pricing changes, patient payment amount changes, client or provider eligibility changes, and other changes necessitating reprocessing of multiple claim records.
CAT170	Maintain an online mass-adjustment selection screen, limited to select users, to enter selection parameters including but not limited to parameters such as time period, program, provider number(s), client number(s), service code(s), procedure codes, and claim type(s); claim records meeting the selection criteria will be displayed for initiator review, and the initiator will have the capability to select or unselect chosen claim records for continued adjustment processing.
CAT171	Provide a retroactive rate adjustment capability which will automatically identify all claim records affected by the adjustment, create adjustment records for them, reprocess them, and maintain a link between the original and adjusted claim.
CAT172	Integrate accurate reporting of denials or cutbacks into claims processing with HIPAA compliant Remittance Advice (RA) Codes.
CAT173	Generate reports to meet federal and state reporting requirements.
CAT174	Verifies that the provider is eligible to render service(s) during the period covered by the claim.
CAT175	Adjudicates claims using provider NPI or atypical provider number, taxonomy, and address information.

Claims Processing – Technical Requirements	
CAT176	Edit all claim records for provider parameters such as validity of ID number, eligibility on date of service, prepayment review indicator, provider taxonomy to service rendered, group participation, current licensure, and CLIA certification.
CAT177	Verify that all providers listed on the claim (e.g., servicing, rendering, billing) are eligible to render the billed service based on provider type, license, category of service, and provider taxonomy code values.
CAT178	Establish a Category of Service for the claim record based on, provider taxonomy, funding source, claim type, billing form (e.g., CMS-1500, UB-04, ADA Dental-2006,Pharmacy, and Point of Sale), and other components used in claim record processing.
CAT179	Verifies that the provider is eligible to provide the specific service covered by the benefit plan to the specific client.
CAT180	Verifies that the client was eligible for the particular category of service at the time it was rendered.
CAT181	Edit claims for services covered by the MCO for clients enrolled in Managed Care benefit package.
CAT182	Edit all claim records for client parameters such as name and date of birth to ID number match, eligibility on date of service, prepayment review indicator, aid category, client place of residence, MCO enrollment, Seriously and Persistently Ill (SPI) status, and whether service rendered is included or excluded from the client's predefined service package (for example, Chronic Renal Disease Program CRDP, restricted, hospice, managed care, family planning, non-qualified non citizen, QMB).
CAT183	Flags for review claims, for the same client, with a diagnosis and procedure which indicate an emergency that occur within one day of a similar claim from the same provider.
CAT184	Identifies, by client, the screening and related diagnosis and treatment services the client receives for Early and Periodic Screening Diagnosis, and Treatment, (EPSDT).
CAT185	Routes and reports on claims that are processed that indicate the client's date of death for follow-up by the client eligibility or Third Party Liability (TPL) and/or estate recovery personnel.
CAT186	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 clients as scheduled or requested.
CAT187	Provides and maintains the capability to pend or deny claims for clients assigned to the client lock-in program based on state guidelines.
CAT188	Provides and maintains the capability to edit claims for clients in long term care (LTC) facilities to ensure that services included in the LTC payment rate are not billed separately by individual practitioners or other providers.
CAT189	For Long Term Care (LTC) facilities, the DMES must be capable of tracking usage of therapeutic and hospital reserve bed days against the maximum allowable days for each type of leave allowed by DHSS policy.
CAT190	Edit LTC claims records for parameters such as client authorization data, level of care, patient payment amount, bed hold and leave days, and admit/discharge information.
CAT191	Provides and maintains the capability to process client cost sharing (e.g., co-payments, LTC patient liability) on any service specified by the state using a fixed amount or percent of charges.
CAT192	Provide the capability to price LTC claim records on a specific per diem by reimbursement level, a client specific negotiated rate, a percentage of charges, or a facility per diem.
CAT193	Provide the ability to accept and deduct patient payment amounts from LTC claim records and capitation claims for clients residing in nursing or assisted living facilities (including rehabilitation hospital and 30-day acute care LTC stays) and provide the ability to apply

Claims Processing – Technical Requirements	
	patient payment amounts on a pro-rated basis when appropriate.
CAT194	Edits claims for newborns' eligibility based upon State-defined newborn enrollment policies and procedures.
CAT195	Edits for client participation in special programs (i.e., waivers) against program services and restrictions.
CAT196	Limits benefits payable by client eligibility category or other client groupings.

C.5.1.6 Prior Authorization (PA) Business Area

The Contractor will provide a PA function. After medical necessity for service is determined (or pended prior to determination), PAs are entered into the MMIS for certain services, as required by DHSS policy, to indicate service approval and/or to limit benefits within a specified period for a client. The subsystem maintains security and control over PA related data through department defined function level security. Access to PA information is facilitated by the system's extensive online, real-time inquiry.

Inputs to the PA function may include online data entry through a State authorized Contractor. Connectivity to that Contractor would be required.

Some objectives of the Prior Authorization Business Area are:

1. Generate Prior Authorization Notices
2. Update and Maintain Prior Authorization Data
3. Allow Online Access to Prior Authorization Data
4. Produce Prior Authorization Reports

C.5.1.6.1 Contractor Business Responsibilities

Prior Authorization – Business Responsibilities	
CRB49	Enter data to the PA function through batch entry or online, at the State's direction, based on DHSS approved flow charts within the same business day, except for the final hour before close of business (COB).
CRB50	Maintain, produce, and mail PA notices of approved, denied, or suspended PA requests to providers and bilingual notices to clients.
CRB51	Maintain and provide training to State staff in the use of the PA screens, windows, and reports.
CRB52	Mail regular PA letters within 2 days of receipt.

C.5.1.6.2 Contractor Technical Requirements

Prior Authorization – Technical Requirements	
CAT197	Processes and retains all prior authorization request data.
CAT198	Ensures that there is a field for authorization or identification when an override indicator (force code) is used.

Prior Authorization – Technical Requirements	
CAT199	Supports receiving, processing and sending electronic health care service review, request for review, and response transactions required by 45 CFR Part 162, as follows: a. Retail pharmacy drug referral certification and authorization b. Dental, professional and institutional referral certification and authorization (ASC X12N 278) c. Optionally, supports Web or Internet submissions or prior authorization requests
CAT200	Enables the prior authorization staff to send requests for additional information on paper or electronically.
CAT201	Supports searching for prior authorizations based on: a. Provider name b. Provider ID and NPI c. Client name d. Client Medicaid ID Number e. Date of submission range f. Dates of service requested range g. Service requested h. Status of the request
CAT202	Supports retroactive entry of prior authorization requests.
CAT203	Assigns a unique prior authorization number as an identifier to each prior authorization request.
CAT204	Edits prior authorization requests with edits that mirror the applicable claims processing edits.
CAT205	Establishes an adjudicated prior authorization record, indicating: a. Client b. Status of the request c. Services authorized d. Number of units approved per day, week, month or other specified period as well as a maximum # of units for a longer specified period. e. Service date range approved f. Cost approved g. Provider approved (unless approved as non-provider-specific)
CAT206	Load external prior authorization files before each adjudication cycle and upon DHSS approved schedule
CAT207	Edits to ensure that only valid data is entered on the prior authorization record, and denies duplicate requests or requests that contain invalid data.
CAT208	Captures and maintains both the requested amount and authorized amount on the prior authorization record.
CAT209	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.
CAT210	Accepts updates from claims processing that “draw down” or decrement authorized services.
CAT211	Edit all claim records for prior authorization requirements such as presence and validity of prior authorization number, number of units authorized and used, and whether service and service date are consistent with authorization.
CAT212	Update the prior authorization record to reflect the services paid on the claim and the number of services still remaining to be used.
CAT213	Identify claims that are associated with each Prior Authorization.
CAT214	Uses imaging equipment to capture, store, and retrieve hard copy prior authorization

Prior Authorization – Technical Requirements	
	requests and associated documents.
CAT215	Generates automatic approval and denial notices to requesting and assigned providers, case managers, and clients for prior authorizations. Denial notices to clients include the reason for the denial and notification of the client's right to a fair hearing.
CAT216	Provides and maintains a toll free telephone number for providers to request prior authorizations.
CAT217	Generate reports to meet federal and State reporting requirements.

C.5.1.7 Financial Management

The Financial Business Area processes and tracks all financial activity within the MMIS, including claim payments, claim adjustments, cash receipts, refunds, financial payouts, accounts receivable, and system-generated transactions for all accounts. Accounts in the Delaware MMIS include providers, clients, carriers, and drug manufacturers. The Financial cycle is run weekly to process all financial transactions and generate payment records. These payment records are used to create electronic fund transfers (EFTs) and generate paper checks when necessary. Provider remittance advices (RAs) are created and sent to providers electronically and on paper.

Examples of objectives for the Financial Business Area are:

1. Maintain account ledger and financial history data.
2. Process claim adjustments.
3. Report provider earnings via issuance of 1099s.
4. Produce payments.
5. Collect and Disposition Cash Receipts as directed by the State.
6. Produce remittance advices.
7. Follow Generally Accepted Accounting Principles (GAAP).

C.5.1.7.1 Contractor Business Responsibilities

Financial Management – Business Responsibilities	
FIB1	Monitor client premium payments on the Provider Cash Report (FNDR210) for purposes of transferring monies via wire transfer to DHSS/DMS when accrued premium payment balances exceed $1,000.
FIB2	Identify for DHSS Workers with Disabilities (MWD) clients who are no longer enrolled in the MWD program and have a cash receipt or premium adjustment that has not been used and issue a premium refunds when notified by the State.
FIB3	Issue premium refund for MWD clients when notified by the State.
FIB4	Generate for each newly enrolled client in the MWD program, the necessary financial transactions to display on the initial invoice.
FIB5	Produce the monthly MWD invoice.
FIB6	Accept and apply premium payments for MWD clients.
FIB7	Produce electronic and/or paper remittance advices (RAs) at the direction of the State.
FIB8	Pay providers via Electronic Funds Transfer (EFT).
FIB9	Maintain security for checks during the matching/stuffing/mailing process.
FIB10	Ensure that appropriate internal controls and segregation of duties, in accordance with

Financial Management – Business Responsibilities	
	Generally Accepted Accounting Principles (GAAP), are adhered to in all aspects of banking services.
FIB11	Be responsible for any losses resulting from inadequate internal controls or misappropriation of funds by its employees.
FIB12	Provide the stock of blank drafts to be used in paying benefits and any hardware and software used by the Contractor for laser check printing.
FIB13	Print checks within four hours of the State's approval and will have emergency procedures established to print checks within four hours, on another printer, should the primary check printer become non-functional.
FIB14	All system-generated payments must be posted to the DMES in conjunction with the completion of the weekly payment cycle. (All manual issuance of special payments must be posted to the DMES within 14 calendar days of the issuance of the payment).
FIB15	Develop and update banking and finance desk level operating procedures that provide for all appropriate internal controls and segregation of duties. These procedures will require State review and approval.
FIB16	Develop and maintain appropriate records regarding the transfer of printed checks from the banking department to the mailroom. The number of checks transferred from the banking section must match the number of checks delivered to the mailroom. The Contractor must confirm that the number of checks processed through the postage machine agrees with the number of checks delivered. Auditable records are required.
FIB17	Maintain a database/spreadsheet reconciliation procedure to ensure duplicate manual checks are not issued as replacement for the same check/purpose, etc. The ability to sort this database various ways will allow reviewers to determine matching data on separate entries and find errors. The Contractor is responsible and accountable for all manual checks issued. A copy of the database, both printed and electronic, will be provided to the State on a periodic basis (weekly or monthly) for audit/review.
FIB18	Maintain and reconcile payments (including the check register) and the check write files before transfer to DHSS at the end of each claim records payment cycle and reconcile discrepancies.
FIB19	Accept and process the U.S. Internal Revenue Service 1099 Form data, review provider 1099 earnings reports, notify providers regarding discrepancies, and reconcile discrepancies.
FIB20	Perform adjustments to original and adjusted claim records and create documented audit trail for each transaction.
FIB21	Receive and process incoming checks from payers and providers sent to DHSS.
FIB22	Open a cash receipt for all incoming payments and disposition according to State appropriated rules.
FIB23	Update claim history and online financial files with the check number, date of payment, and amount paid after the claim records payment cycle.
FIB24	Issue check issuance requests to DHSS for providers, at any time during the weekly payment cycle, when requested and authorized by the State to do so.
FIB25	Produce all reports necessary to meet federal and State reporting requirements. All reports shall be available for retrieval through the online reporting function.
FIB26	Monitor the status of each accounts receivable and report monthly to the State in aggregate and/or individual accounts, both on paper and online.
FIB27	Follow and monitor compliance with written procedures to meet State and federal guidelines for collecting outstanding accounts receivable.
FIB28	Maintain online access to financial information according to State specifications.
FIB29	Enter non-claim specific financial transactions received and processed at the Contractor location such as but not limited to: SUR settlements, drug settlements, recoupments,

Financial Management – Business Responsibilities	
	returned warrants, refunds and cash transactions.
FIB30	Enter claim-specific financial transactions received and processed at the Contractor location such as but not limited to: adjustments, voids, recoupments, refunds, drug rebate.
FIB31	Make recommendations related to any area in which the Contractor thinks improvements can be made.
FIB32	The Contractor shall produce, print, and distribute all checks produced within the DMES or required by the State.
FIB33	Adjudicate 100% of clean claim records (including encounter records and Managed Care Organization risk adjustments) in the next payment processing cycle without limit.
FIB34	Make available on the provider bulletin board Remittance Advices within 1 business day of the completion of the financial cycle.
FIB35	Produce 1099 earnings reports for providers and Contractors of the State and distribute no later than January 31st each year, and report to the Internal Revenue Service in accordance with federal law.
FIB36	The Contractor shall maintain a consolidated accounts receivable function, by program and type and provider, and deduct/add appropriate amounts and/or percentages from processed payments.
FIB37	Maintain an itemization of suspended claim records, including dates of receipt and suspense, and dollar amount billed.
FIB38	Maintain adjusted claim information showing both the original claim information and the adjusted information, with an explanation of the adjustment reason code.
FIB39	Print informational messages on RAs as directed by the State, with multiple messages available on a user-maintainable message text file that is not limited by lines or characters, with parameters such as program, provider type, claim type, and payment cycle date(s).
FIB40	Maintain the current provider check-write information back through the most recent completed federal tax year online.
FIB41	Meet the requirements of the federal Cash Management Improvement Act of 1990 (CMIA regulations (31 CFR 205)).
FIB42	Void all non-negotiated provider checks within a timeframe specified by the State.
FIB43	Generate letters to providers when establishing or adjusting accounts receivables.
FIB44	Apply rules supplied by the State to check for reasonableness of each provider payment, report all suspect payments to the State as part of the inspection and balancing reports, and withhold checks or EFT transactions as directed by the State: a. Identify checks that exceed an average threshold supplied by the State b. Identify checks that are the highest amounts, above a threshold set by the State, within a provider type c. Identify checks for new providers or providers that have not billed in a long time, as determined by the State
FIB45	Manually pull and void provider checks and remittance vouchers after printing at the State's request.
FIB46	Remove EFT payments from the banking file prepared for EFT transfer file (scrub); pull and remove remittance vouchers at the State's request. In cases where the State instructs the voiding of a check, the Contractor must adjust (void) any claims associated with the check.
FIB47	Arrange for the special delivery of provider checks. Providers may receive funds by several methods including express mail, wire transfer, and office pickup.
FIB48	Account for all manual checks issued. Manual checks may be required for the following

Financial Management – Business Responsibilities	
	or similar reasons: a. EFT rejects b. EFT scrubs c. Damaged system checks d. Emergency advance payments e. Kick payments f. Disproportionate Share payments g. Internal Revenue Service Tax Levy payments h. Agency Lien payments i. Reissues for forged or improperly endorsed checks j. Reissues for stop payment checks k. Reissues for voided checks l. Reissues for stale dated checks m. Reissues for wire rejects n. Reissues for miscellaneous refunds o. Mass Adjustment issues to the State for undeliverable checks, returned checks, or stale dated checks
FIB49	Perform “Special Check Pulls.” These include such items as: a. Special handling requests b. Undeliverable holds c. State recoupment checks d. IRS recoupments e. Pulling checks as directed by Medicaid Program Integrity
FIB50	Reconcile bank statements within 30 days of receipt for all financial bank accounts tracked via the DMES on a monthly basis or other schedule requested by DHSS.
FIB51	For each manual check issued, the following documentation is required on file: a. Correspondence requesting issuance b. Supervisory approval c. Documentation verifying stop payment or voided check
FIB52	Develop and update (no less than every 6 months) banking and finance desk level operating procedures that provide for all appropriate internal controls and segregation of duties. These procedures will require State review and approval.
FIB53	Transmit the disbursement file to the State Treasurer’s Office by no later than 7:00 a.m., ET, following DHSS authorization, or according to any revised weekly schedules established by DHSS.
FIB54	The Contractor shall be responsible for payment or re-payment to the State of Delaware for any unexpected or unforeseen situation that creates costs the State money.
FIB55	Medicare Premium Payments: The State's Medicare premium liability must be paid to CMS in accordance with U.S. Department of Health and Human Services State Buy-In Manual, publication 100-15. The Contractor must ensure all eligible client premiums are paid and any discrepancies with CMS are resolved on a schedule defined by DHSS.
FIB56	All stale dated, undeliverable, stop payments and returned checks must be posted to the MMIS within 30 calendar days of the completion of the reconciliation of the current month’s bank statement.
FIB57	Create an automated process for capturing "off cycle" manual payments on the provider/contractor 1099.
FIB58	The Contractor, in addition to updating claim history, shall update accounts receivable files with the specific Medicaid ID, check number, date of payment, and amount paid after the claim records payment cycle.

Financial Management – Business Responsibilities	
FIB59	Monitor the status of each aged account receivable and report to the State in aggregate by funding source and area of operation. The report shall present the data in executive summary level, and detail level formats.
FIB60	Print informational messages on RAs as directed by the State, with multiple messages available on a user-maintainable message text file that is not limited by lines or characters, with parameters such as program, provider type, claim type, and payment cycle date(s).

C.5.1.7.2 Contractor Technical Requirements

Financial Management – Technical Requirements	
FIT1	Provides individual Explanation of Benefits (EOB) notices with reason, remark, and denial codes, 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.
FIT2	Updates claims history and online financial files with payment identification (check number, EFT number, warrant number, RA number or other), date of payment, and amount paid after the claims payment cycle.
FIT3	Maintains garnishments and tax levies and assignment information to be used in directing or splitting payments to the provider and garnishor.
FIT4	Maintains financial transactions in sufficient detail to support production of calendar year 1099 provider earned income statements. If the State elects to do, also support W-2 and FICA reporting requirements for personal service care providers and providers of services under self-directed care initiatives.
FIT5	Accounts for recovery payment adjustments received from third parties that do not affect the provider's 1099/W2.
FIT6	Maintain a process to accommodate issued voided and/or reissued checks by the State and the required posting to the specific provider's account to adjust the provider's 1099 earnings data and/or set up recoupment criteria.
FIT7	Provides a full audit trail including daily financial transactions related to: newly opened A/Rs and A/Ps, adjustments to previously opened A/Rs and A/Ps, and cash activities to the general ledger transaction generated by the MMIS. The audit trail will provide sufficient data to perform bank account reconciliations and create A/R and A/P schedules or other supporting financial requirements.
FIT8	Maintain sufficient controls to track all financial transactions. Open batches for all financial transactions, balance each batch, and maintain appropriate audit trails on the claims history to explains why A/R or A/P were created/adjusted/deleted.
FIT9	Provide the ability to track and report financial and claim activity based upon NPI and taxonomy
FIT10	Provides automated processes for performing periodic bank account or fund allocation reconciliations by operational area.
FIT11	Account for non-negotiated warrants (for example, payments that were never cashed) in the system to aid bank account reconciliation and resolution of inquiries.
FIT12	Provide cash management techniques (such as zero-balance bank accounts) which meet the requirements of the Federal Cash Management Improvement Act of 1990 and the State.
FIT13	Maintains an accurate history of claim recovery payments in excess of expenditures and allows distribution to the appropriate parties, including providers, clients, or insurers.
FIT14	Maintains a history of refunds by funding source and operational area.
FIT15	Produce an online report detailing all refunds by check number, date, claim control number, and deposit number. Also provide online summaries of transactions processed

Financial Management – Technical Requirements	
	and account balances.
FIT16	Provide a method to link full or partial refunds to the specific claim(s)
FIT17	Accept claim-specific and gross recoveries, regardless of submitter (provider, insurance company, recipient, drug manufacturer); apply gross recoveries to providers and/or recipients as identifiable.
FIT18	Withholds the federal and state share of payments to Medicaid providers to recover Medicare overpayments.
FIT19	Maintain a consolidated accounts receivable function, by program and type and provider, and deduct/add appropriate amounts and/or percentages from processed payments to include a collections module
FIT20	Maintain a process to automatically establish a new account receivable for a provider when the net transaction of claim records and financial transactions results in a negative amount.
FIT21	Create the ability to tag and report any A/R s by type and operational area.
FIT22	Create flexibility in customizing repayment schedules for A/R balances.
FIT23	Support automated collection of accounts receivables capabilities, including the ability to receive electronic payments.
FIT24	Provide automated data import capabilities for the posting and collections of accounts receivables.
FIT25	Maintain an online recoupment process that sets up provider accounts receivables that can be either automatically recouped from claim records payments or satisfied by repayments from the provider or both.
FIT26	Maintain a methodology to apply monies received toward the established recoupment to the accounts receivable file, including the RA date, number, and amount, program, and transfer that data to an online provider paid claim records summary.
FIT27	Provide the capability to generate letters to providers when establishing or adjusting accounts receivables.
FIT28	Create a reporting process to identify outstanding A/Rs.
FIT29	Allow restrictive, access to authorized staff to enter payment requests.
FIT30	Ability to enter payment requests and adjustment requests online.
FIT31	Ability to correct data on the “proof” run if errors are found.
FIT32	Tracks Medicare deductibles and coinsurance paid by Medicaid for all crossover claims, by ICN, client and program type.
FIT33	Processes and retains all data from provider credit and adjustment transactions by reason code.
FIT34	Produces payment instruments (both warrants and EFT transactions) or transfers payment information to the payment issuing system.
FIT35	Maintain capability to identify Providers specific details (bank accounts, routing numbers, etc) authorized for electronic claims submission (ECS) by required versions, electronic funds transfer (EFT), and electronic remittance voucher.
FIT36	Display start and ending dates for current and historical EFT,
FIT37	Issues a remittance advice detailing claims processing activity at the same time as the payment or payment information transfer.
FIT38	Generate provider remittance advices (RAs) in electronic and/or hard-copy media making them accessible on the next business day following the payment cycle. Information contained on the RA shall include but not be limited to: a. An itemization of submitted claim records that were paid, denied, or adjusted, and any financial transactions that were processed for that provider, including subtotals and totals b. An itemization of suspended claim records, including dates of receipt and suspense,

Financial Management – Technical Requirements	
	and dollar amount billed, with an explanation of the suspension reason code c. An itemization adjusted claim information showing both the original claim information and the adjusted information, with an explanation of the adjustment reason code d. Indication that a claim has been rejected due to TPL coverage on file for the recipient and include available relevant TPL data on the RA e. Full English language explanatory EOB messages relating to the claim payment reduction, denial, or suspension f. Summary section containing earnings information, by program, regarding the number of claim records paid, denied, suspended, adjusted, in process, and financial transactions for the current payment period, month-to-date and year-to-date g. An Accounts Receivable detail and summary section, containing for each account the beginning balance, activity for the period, ending balance, the recoupment schedule, and totals; and list all relevant error messages per claim header and claim detail which have caused a claim to be denied or suspended
FIT39	Provide the capability to print informational messages on remittance advices, with multiple messages available on a user-maintainable message text file, with parameters such as program, provider type, claim type, and payment cycle date(s).
FIT40	Provide the flexibility to suppress the generation of (both zero-pay and pay) check requests for any provider or provider type but generate associated remittance advices.
FIT41	Ensures that the system supports sending electronic claim payment/advice transactions (ASC X12N 835) meeting the standards required by 45 CFR Part 162.
FIT42	Stores the remittance advice (ASC X12N 835) in the most recent HIPAA format.
FIT43	Provides payment via electronic funds transfer (EFT) as an option.
FIT44	Nets provider payments against credit balances or accounts receivable amounts due in the payment cycle in determining the payment due the provider.
FIT45	Processes void and replacement checks for incorrect payments or returned warrants, crediting fund source accounts and creating accounts receivable or credit balances where appropriate.
FIT46	Accept returned checks and void the original provider payment by automatically reversing all transactions associated with the payment, including claim payments, claim credits, and other financial transactions.
FIT47	Supports stop payment processes.
FIT48	Allows online access to accounts receivable or provider credit balances to authorized individuals.
FIT49	Allows online access to remittance advice through a Web-based browser.
FIT50	Provides support for identification and application of recovery funds and lump-sum payments.
FIT51	Identifies providers with credit balances and no claim activity during a state-specified number of months.
FIT52	Notifies providers when a credit balance or accounts receivable has been established.
FIT53	Displays adjustment/void in a separate section of the remittance advice.
FIT54	Allows for withholding of payments in cases of fraud or willful misrepresentation without first notifying the provider of its intention to withhold such payments.
FIT55	Maintain a process to suspend, pull and/or deny claims when a provider is sanctioned or administrative action is taken.
FIT56	Supports the payment and tracking of Provider Incentive Payments (PIP) including, but not limited to the ability to differentiate between IPs that were paid to EHs vs. EPs and provide

Financial Management – Technical Requirements	
	a cumulative history to show all IPs issued by DHSS for a specific applicant/payee
FIT57	Maintain a process to track drug rebate activities by manufacturer and by drug rebate invoice type and funding source, including the billing of labeler, calculation of interest, adjustments, write-offs, and collections
FIT58	The drug rebate module shall provide an interface with CMS that can exchange and receive data (unit rebate amounts (URA/NDC utilization)) for purposes of generating current labeler invoices and adjusting previously issued labeler invoices.
FIT59	Create drug rebate invoices in electronic and paper formats including generating electronic notification and generating the corresponding open A/R.
FIT60	Create the ability to record and disposition drug rebate labeler payment at the NDC level.
FIT61	Provide the ability to adjust drug rebate credit amounts across quarters, invoice types, funding sources and labelers
FIT62	Track all financial transactions, by program and funding source, to include TPL recoveries, fraud and abuse recoveries (to include RAC & MIC), provider payments, drug rebates, and so forth.
FIT63	Capture other insurance amounts to include Medicare crossover claims.
FIT64	Create a monthly A/R aging detail listing drug rebate labeler balances.
FIT65	Create a quarterly summary of drug rebate A/R by funding source and by invoice type.
FIT66	Provides a financial transaction application for processing non-claim specific financial transactions, including payouts, accounts receivable, refund checks, and returned warrants.
FIT67	Supports the process of issuing a manual check, retaining all data required for fund source determination, payee identification, and reason for check issuance.
FIT68	Updates records to reflect the processing of un-cashed or cancelled (voided) Medicaid checks. Process replacements for lost or stolen warrants and updated records with new warrant information.
FIT69	Maintain the current provider check-write (payroll) information back through the most recent completed federal tax year online.
FIT70	Processes payments from providers for refunds and updates records as needed. Adjusts 1099/W2 reporting.
FIT71	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.
FIT72	Create and forward annual 1099 tape to Feds and provide support as follows: a. The calculation and production of a single 1099 based on Federal Employee Identification Number (FEIN) or Social Security Number (Tax ID) and all accumulated payments to the same Tax ID b. The reconciliation of1099 activity to cash and adjustment reports as well as individual payment reports on a quarterly basis, such that they all agree and are consistent. Display current 1099 balances for a Provider within the MMIS. c. The ability to make 1099 adjustments within the system and see the 1099 balance real time as the changes are made d. Respond to all Provider inquiries regarding 1099s including incorrect FEINs e. Resolve all 1099 issues regarding correct reporting of tax information based on IRS policies f. Research and resolve problems identified by Providers with 1099s g. Issue amended 1099s if research indicates inaccuracies on original or prior amended 1099s. Retain the original 1099 values when an amended 1099 is produced. h. Resolve 1099 issues required by the IRS following B1 and B2 protocols to avoid

Financial Management – Technical Requirements	
	penalties i. Produce and disseminate 1099 reports that are federally mandated to be sent out by January 31 each year j. Send out revised 1099 reports per federal guidelines.
FIT73	Send out B Notices no later than November 15 and resolve them no later than December 31st each year.
FIT74	Maintain an online retrieval of 1099 history for 7 years.
FIT75	Routinely reconcile capitation payments to MCO spans in an automated fashion, generate reports for variances, and automatically reverse the incorrect amounts generating a payment/receivable per DHSS requirements.
FIT76	Create a process to bill, adjust and collect payment interest charges on clean claims, accounts receivable, and accounts payable as defined by DHSS.
FIT77	Maintain online provider accounts showing claims paid month to date, State fiscal year to date and prior State fiscal year by DHSS benefit plan.
FIT78	System must be able to create A/R for premiums (prospectively and retroactively).
FIT79	System must produce monthly statements and have ability to mail to alternate addresses other than client.
FIT80	System must have capability to adjust monthly premium amount up or down, when a payment has been previously applied.
FIT81	Create the ability to view, add, or update premium waivers. A premium waiver is issued to alleviate the client's financial responsibility for the payment of a monthly premium.
FIT82	Create an automated and manual client disenrollment process when premium payments aren't received based upon DHSS instruction.
FIT83	Create a process that will check for an enrollment change in the current month that could result in a premium overpayment by the client. If an overpayment has occurred because of the eligibility change, call a common module to create an adjustment transaction to be stored on the new adjustment screens.
FIT84	Create a process to identify clients who are no longer enrolled in a program and have a cash receipt or premium adjustment that has not been used. If either is found, a payout will be created and sent.
FIT85	Produce financial reports summarizing paid, adjusted and unpaid premiums.
FIT86	Create a Web Portal that will accept and process premium and other payments.
FIT87	Produce incentive payment records and send them to the MMIS for processing or to reports.
FIT88	Calculate the proper incentive payment at the proper time

C.5.1.8 Electronic Verification System

The Electronic Verification System (EVS) allows providers to access client, provider, claims, prior authorization, and financial information. This is accomplished through Point of Service (POS) systems, electronic claims submission software, the Automated Voice Response (AVR), an Electronic Claims Management System (ECMS), and the DMAP website. The DMAP website will be discussed in a separate section of the RFP.

Information available through all avenues of the EVS including, but are not limited to:

1. Client eligibility information
2. Third Party Liability data

3. Managed care enrollment
4. Lock-in status
5. Program limitations and service limits exhausted by client
6. Claim status
7. Batch claims status
8. Check-write information from the most recent payment cycle
9. Prior authorization

Objectives of the EVS Business Area are:

1. Maintain easily accessible pathways to information
2. Provide up-to-date information on client eligibility
3. Authorize POS transactions quickly
4. Provide current PA, claim status and check-write information to providers

C.5.1.8.1 Contractor Business Responsibilities

Electronic Verification System – Business Responsibilities	
PMB1	Provide access to the EVS in a variety of methods, including personal computer, the Internet, telephone, etc.
PMB2	Supply, install, and operate the necessary software and communication lines required for providers to access the EVS utilizing their own equipment such as personal computers, telephones, and telephone lines.
PMB3	Provide the necessary training to providers and State personnel in how to use the EVS, as directed by the State.
PMB4	Update and maintain EVS User Manuals for providers and State staff. Review at least annually for State approval.
PMB5	Produce all EVS-related reports according to State specifications.
PMB6	Maintain Emergency Plan for EVS to be approved by the State that will uphold all performance level requirements of the EVS.
PMB7	Log and track all inquiries from providers.
PMB8	Make recommendations on any area in which the Contractor thinks improvements can be made.
PMB9	Provide sufficient access lines so that Delaware medical assistance providers do not encounter busy conditions at least 95% of the time.
PMB10	Provide a backup system to assure that voice response system and the associated network downtime is limited to a maximum of 30 continuous minutes.
PMB11	Provide a response time of less than 4 seconds for all navigation through voice responses and electronic screen responses.
PMB12	Provide electronic verification availability 24x7, except for agreed upon downtime for updates and preventative maintenance.
PMB13	Provide the telephone system infrastructure required to operate the EVS.
PMB14	Provide connectivity and secured access for Provider computer systems.
PMB15	Maintain Record Search Time – The response time must be within 4 seconds for 95% of the record searches.
PMB16	Maintain Record Retrieval Time – The response time must be within 4 seconds for 95% of the records retrieved.

Electronic Verification System – Business Responsibilities	
PMB17	Maintain Screen Edit Time – The response time must be within 2 seconds for 95% of the time.
PMB18	Maintain New Screen/Page Time – The response time must be within 2 seconds for 95% of the time.
PMB19	Maintain Print Initiation Time – The response time must be within 2 seconds for 95% of the time.
PMB20	Maintain Electronic Verification System Response Time – The response time must be within 4 seconds for 95% of the time.
PMB21	Provide various levels of security within the DMES online applications, including unique logons requiring password for each user.
PMB22	The Contractor shall operate and maintain a testing environment, which simulates a production environment and allows for unique identification of test claim records, test providers, and test clients to maintain the integrity of the test data.
PMB23	The Contractor shall maintain, support, and provide the State with online access to the testing environment and all test files to submit test data independently without notice to the Contractor.
PMB24	The Contractor shall report on the impact of test cycles and compare those results to the actual processing results.
PMB25	The Contractor shall keep all test outputs separate from routine DMES outputs and clearly label all outputs as test outputs.
PMB26	The Contractor shall produce and review all control reports generated for each update and processing cycle.
PMB27	The Contractor shall provide all test outputs within the time periods determined by the State.
PMB28	The test facilities must perform test file transfers and accept transmitted test data from all systems the production DMES is expected to accommodate.
PMB29	The AVR will correctly and timely provide client eligibility information as directed by the State, to include, but not limited to: a. TPL information b. Managed care enrollment c. Lock-in status d. Program limitations e. Claim status f. Check-write information from the most recent payment cycle g. Service limits exhausted by the client h. Prior authorization i. Provider access PIN update capability
PMB30	The electronic claims submission software must provide accurate information in a timely manner to include: a. Interactive client eligibility information, including: 1. TPL information 2. Managed care enrollment 3. Lock-in status 4. Program limitations 5. Service limits exhausted by client b. Batch client eligibility information, including: 1. TPL 2. Managed care enrollment 3. Lock-in status

Electronic Verification System – Business Responsibilities	
	4. Program limitations 5. Service limits exhausted by client. 6. Batch claim status
PMB31	Interact with pharmacy POS Contractors to quickly return client eligibility information.
PMB32	The Contractor must supply DHSS an inventory report of all system database tables, data, and files backed up and archived every 6 months or upon DHSS request.

C.5.1.9 Mail Room Requirements

Operation of the FA Contractor Mailroom includes incoming and outgoing mail, distribution, returned mail processing, and miscellaneous mailroom activities. Specific requirements for the Contractor Mailroom include, but are not limited to:

C.5.1.9.1 Contractor Business Responsibilities

Mail Room – Business Responsibilities	
MRB01	Mail provider enrollment packages.
MRB02	Process general inbound and outbound mail.
MRB03	Return of hard-copy claims missing required data to the sender.
MRB04	Log and secure all inbound checks at the earliest possible point.
MRB05	Mail checks to providers.
MRB06	Mail notification of payment denials.
MRB07	Mail gross adjustment letters.
MRB08	Mail pharmacy benefits information card and brochure and the DMAP identification card to all new clients eligible for pharmacy benefits.
MRB09	Support, generate, and distribute all forms, letters, and correspondence related to the DPAP, including but not limited to: applications, brochures, return envelopes, acceptance and denial letters, termination letters, recertification requests, and enrollment forms.
MRB10	Mail all letters associated with the Cancer Treatment Program (CTP).
MRB11	Mail letters to Medicaid for Workers with Disabilities (MWD) clients, sending letters with different verbiage for active clients and pending clients.
MRB12	Mail welcome letters to newly eligible and newly enrolled MWD clients. Clients will receive a monthly invoice. Past due accounts also will be indicated on the monthly invoice. If coverage is cancelled, a disenrollment letter will be sent to confirm the cancellation.
MRB13	Mail the MWD premium invoices.
MRB14	Mail the disenrollment letter for clients disenrolling in the MWD.
MRB15	Mail immunization letters to all eligible families about EPSDT services.
MRB16	Mail all outreach and EPSDT information/notification/reminder letters monthly or as specified by the State.
MRB17	Mail applications to prospective clients.
MRB18	Mail applications and renewals, informational brochures, and replacement identification cards.
MRB19	Mail all enrollment packets and contracts to providers.
MRB20	Mail enrolled providers a start-up packet containing all the information for participation in the Delaware Medicaid program.
MRB21	Mail 1099s to providers annually.

Mail Room – Business Responsibilities	
MRB22	Mail B notices.
MRB23	Monitor, control, and report metrics and QC statistics on Mailroom operations and activities.
MRB24	Prepare and control all incoming and outgoing Delaware Medicaid Assistance Program mail.
MRB25	Produce and mail notices or letters in State-defined formats to clients and providers as directed by the State.
MRB26	Handle all mailings and postage as directed by the State.
MRB27	Mail drug rebate invoices and rebate adjustments.
MRB28	Maintain security for checks during the matching/stuffing/mailing process.
MRB29	Mail PA notices of approved, denied, or suspended PA requests to providers and bilingual notices to clients.
MRB30	Mail paper claim facsimiles, microform claim copies, and/or billing forms to invoice third parties. Mail TPL post payment recovery request letters.
MRB31	The FA Contractor will provide and maintain a secured courier service for transporting documents with Protected Health information (PHI) between State offices, generally the Lewis building, and the Contractor site. The courier service will be required to perform daily runs, use secure packaging for all documents or items, store and maintain tracking data from point of origin to destination including date and time, and proof of delivery.
MRB32	Mail claim forms and other billing documents to providers.
MRB33	Mail Certificate of Creditable coverage to clients or former clients.
MRB34	Mail outreach packets to identified families.
MRB35	Mail client brochures and information cards to all heads of households with pharmacy program information
MRB36	Mail program applications and other program information as requested.

C.5.1.9.2 Contractor Technical Requirements

Mail Room – Technical Requirements	
MRT1	Provide ability to produce mailing labels to support outreach efforts and in order to mail necessary materials.

C.5.2 Pharmacy Benefits Management (PBM)

C.5.2.1 Pharmacy Point of Service (POS) Business Requirements

Pharmacy POS – Business Requirements	
POSB1	Provide the equivalent of three FTE of pharmacist time.
POSB2	Provide a Pharmacy Call Center through a dedicated phone line – Monday through Friday 8:00 a.m. - 5:00 p.m. ET, excluding Holiday and emergency closings for Clients, staffed by registered pharmacy technicians or individuals with a minimum of 3 years experience working in a pharmacy.
POSB3	Respond to all manufacturer questions and surveys related to product status within 5 days.
POSB4	Respond to practitioners who have non-patient specific questions related to the program within 3 business days.
POSB5	The PBM shall regularly contribute timely articles for provider newsletters and alerts regarding updates to prior authorization, tips, and billing guidelines.
POSB6	Develop provider and client notices and educational materials as it pertains to policy changes as directed by the State.
POSB7	Communicate with the Medical Society of Delaware and the Delaware Pharmacists Society to expedite provider and pharmacy notification about pharmacy benefits.
POSB8	Publish PDL information through the DMAP website.
POSB9	The PBM shall make recommendations for clients to be locked into a pharmacy to streamline the work effort for the Surveillance and Utilization Review (SUR) team within 3 business days of the request.
POSB10	Establish a procedure to redirect calls to the appropriate department or agency.
POSB11	Review the client's history and prepare an appeals summary within 72 hours of receiving the appeal request following the same procedures as the DHSS team, send a pharmacy technician to the fair hearing to act as a presenter and a pharmacist to serve as a witness.
POSB12	Address prospective DUR alerts.
POSB13	Maintain current audits and create new pharmacy limitation audits as necessary.
POSB14	Maintain and revise dose optimization policy via the Drug File Maintenance Screen.
POSB15	Provide ePrescribing functionality at a minimum allowing eligibility check and

Pharmacy POS – Business Requirements	
	benefit/policy check, and performing clinical appropriateness for therapy (e.g., diagnosis and age), offering method for requesting medication history and routing ePrescriptions to a pharmacy of choice.
POSB16	Provide ePrescribing monthly statistics and scan them into a electronic repository for document storage and on demand document retrieval detailing prescriptions generated, PBM information, trend information, and performance.
POSB17	Handle all mailings and postage as determined by the State.
POSB18	Operate prospective components of the Drug Utilization Review function of the DMES.
POSB19	Interface with POS equipment or software currently in use in pharmacies.
POSB20	Provide claim data to pharmacies to support real-time, prospective DUR actions, education efforts, and counseling.
POSB21	Provide online claim records adjudication.
POSB22	Provide a pharmacist consultant to support DUR activities.
POSB23	Develop draft review standards and criteria which can be used to flag individual clients and providers for exceptional drug utilization patterns.
POSB24	Facilitate four DUR Board meetings annually.
POSB25	Present draft standards and criteria to the DUR Board for review and make any modifications requested by the Board.
POSB26	Provide training to State, PBM staff, or providers on application of Retro-DUR methodologies.
POSB27	Provide support to pharmacy TPL issues.
POSB28	Deliver all Pro-DUR/ECM reports within the time frame specified by the State.
POSB20	Review literature and findings on Pro-DUR and report to the DUR Board and the State on a regular basis.
POSB30	Use client and provider data and drug claim records for all State programs for Retro-DUR.
POSB31	Provide a pharmacist consultant to be available to manage and direct the Retro-DUR for the State and act as a DHSS representative to the DUR Board.
POSB32	Provide a Retro-DUR system and a paper format to identify and monitor drug usage for fee-for-service claim records.
POSB33	Provide a Retro-DUR system to identify and monitor disease state management.
POSB34	Generate retrospective data for DUR with monthly updates and summaries.
POSB35	Produce letters for focused educational interventions based on Retro-DUR to both providers and clients.
POSB36	Produce reports on the functional processes of the Retro-DUR activities.
POSB37	Deliver all Retro-DUR reports within the time frame specified by the State.
POSB38	Review literature and findings on Retro-DUR and report to the DUR Board and the State on a regular basis.
POSB39	Provide ad hoc data as requested by Medicaid Fraud Control Unit (MFCU) for qui tam Global Drug Settlements.
POSB40	Provide a pharmacist familiar with DHSS policy at all times that the call center is operational to be available to respond to call center questions, with exceptions made for meetings/special events with advance permission from DHSS.
POSB41	Provide external entities with data as approved by DHSS.
POSB42	Maintain the 340B List of Excluded Individuals/Entities (LEIE) on the DMES.
POSB43	Maintain the PDL indicators for all impacted NDCs.

C.5.2.2 Pharmacy POS General Technical Requirements

Pharmacy POS – Technical Requirements	
POST1	Provides real-time access to Beneficiary eligibility.
POST2	Provides real-time access to provider eligibility, including the pharmacy and prescriber National Provider Identifier (NPI) and (EDI) authorization IDs for electronic submission of claims.
POST3	Provides real-time access to: the State's drug benefit file, Preferred Drug List (PDL), and Prior Authorizations (PAs) or maintains an up-to-date copy for POS use.
POST4	Provide updates, customized to State detailed specifications, to the drug file from a contracted drug pricing service for drug codes and pricing.
POST5	Create and maintain access to a drug file that at a **minimum** contains the following data elements: a. Eleven-digit NDC b. Brand name c. Generic name d. Label name e. Add date f. Effective date g. Terminate date h. CMS termination date i. Obsolete date j. Specific therapeutic class and description k. Identification by ingredient, route of administration and strength l. Previous NDC m. Replacement NDC n. Minimum dosage units and days o. Maximum dosage units and days p. Duration of therapy q. Food and Drug Administration (FDA) Pregnancy Category r. Code equivalent to either GFC or GCN sequence number s. Drug to drug interaction codes t. Unlimited date-specific pricing segments which include all prices needed to adjudicate drug claim records in accordance with state policy u. Indicators for multiple dispensing fees v. Indicators for multiple prices w. Pricing indicators to accommodate four reimbursement methodologies, such as Federal Upper Limit (FUL) state Maximum Allowable Cost (sMAC), Wholesale Acquisition Cost (WAC), NADAC and Average Wholesale Price (AWP) x. Name of manufacturer and labeler codes y. State-specified restrictions on conditions to be met for a claim to be paid including, but not limited to, minimum/maximum days supply, quantities, refill restrictions, recipient age/sex restrictions, medical review requirements, PA requirements, place of service, and the like indicator of prescription status z. Identification of the therapeutic class aa. Identification of discontinued NDCs bb. Identification of CMS Rebate, State Rebate program status and corresponding dates cc. Package size indicator dd. Generic product indicator ee. Identification of strength, units, and quantity on which price is based

Pharmacy POS – Technical Requirements	
	ff. Indication of DESI status (designated as less than effective). gg. DEA designation hh. HCPCS equivalent codes ii. OTC Indicator
POST6	Must allow the drug file to be manipulated to create drug categories that support the DHSS policies
POST7	Provide the ability to have multiple category of service (COS) on the drug file dependent on CMS and DHSS definitions
POST8	Must be able to convert existing Micromedex proprietary number assignments from the drug file to the corresponding DHSS policy using the same or similar coding system.
POST9	Provides real-time access to benefit business rules.
POST10	Provides real-time access to drug file and pharmacy claims history.
POST11	Ensures that all claims are assigned a unique identification number upon entering the system.
POST12	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 7 days after receipt by the POS system of an error free claim.
POST13	Create the ability for providers to use ECM technology to submit pharmacy claim records. The most current version of the NCPDP format and must capture all data used in editing and pricing of pharmacy claims.
POST14	Create an electronic claims management (ECM) system that includes the following capabilities: a. Transmission and online real time processing of pharmacy claim records b. Access to recipient and provider eligibility information c. Prior approval processing d. Notification of co-payment requirements e. Previous drug claim history f. Recipient diagnosis file
POST15	Create a process to ensure that State policy is followed and only valid claim records are paid using edit and audits as prescribed by DHSS.
POST16	Create a process to reverse/adjust a pharmacy claim online within 120 days of claim adjudication.
POST17	Create a process for the pricing of pharmacy claim records according to the appropriate pricing action needed. The system must be able to price a claim specific to the provider taxonomy and provider 340-B status including pricing actions such as FUL, Delaware MAC, Estimated Acquisition Cost for Drugs (EAC), AWP (with or without a percentage), and so forth including the automated pricing of compound drugs in accordance with Delaware policy.
POST18	Create a process for the editing of pharmacy claim records for any parameter such as drugs only covered for recipients over 21 years of age or by sex.
POST19	Create a process to allow editing across claim types to ensure only one provider is billing, for example NDC against HCPCS (injectable J codes and DME) and nursing home against inpatient stays.
POST20	Receive TPL file from Pharmacy TPL Contractor. The file must differentiate between commercial carriers and Medicare B and D.
POST21	Create the ability to export all POS data fields to the DSS/DW.
POST22	Create a process to interface the MMIS with appropriate electronic health records/ePrescriber systems.
POST23	Create a process to interface with and export necessary data to the EHR system to

Pharmacy POS – Technical Requirements	
	support the ePrescriber system.
POST24	Interface with the supplier of the PDL information.
POST25	Create the ability to allow users to enter a drug, generic formulation code (GFC), or list where an alternative drug, GFC, or list can be specified to support PDL alternatives and based on client program eligibility.
POST26	Create the ability to allow a user to enter a drug, GFC, or list where an alternative class ID or subclass ID can be listed to support drug classifications that can be different among programs and based on client program eligibility.
POST27	Create the ability to allow a user to enter a National Drug Code (NDC), GFC, or list along with a 200-character text message to support specific NDC related text messages.

C.5.2.3 Pharmacy ePrescribing Requirements

Pharmacy ePrescribing Requirements	
POST26	Create the ability to allow a user to enter a drug, GFC, or list where an alternative class ID or subclass ID can be listed to support drug classifications that can be different among programs and based on client program eligibility.
POST27	Create the ability to allow a user to enter a National Drug Code (NDC), GFC, or list along with a 200-character text message to support specific NDC related text messages.
POST28	Create the ability to allow exclusion criteria related to an NDC to be returned to the eSignature interface (hub) to support a product coverage exclusion transaction. Products for non-participating manufacturers will be returned in this transaction, specific to the eligibility program that is applicable.
POST29	Create the ability to return each current, active, payable NDC requiring prior authorization.
POST30	Create the ability to report which drugs require step therapy prior to the current drug being approved and report first line therapies in the free text message aforementioned.
POST31	Create the ability to report step therapy rules in other transactions as prescribed by DHSS.
POST32	Create the ability to allow a user to enter a drug, GFC, or list where an alternative step class ID or step subclass ID can be listed to support step medication rules based on a client's program eligibility.
POST33	Create the ability to allow NDCs to be returned in the extract file when the NDC has a quantity limit. All records sent to e Signature hub must be NDC-specific and provide the drug: maximum quantity, and time period associated with the quantity.
POST34	Create the ability to return each current, active, payable NDC with an age restriction based on the age criteria on the DMAP drug file.
POST35	Create the ability to return each current, active, payable NDC with a gender restriction in this transaction based on the gender criteria on the DMAP drug file.
POST36	Create the ability to allow a Web link to be returned to ePrescribing Hub in the extract file.
POST37	Create the ability to allow specific DMAP co-pay rules to be returned based on a client's program eligibility. Its purpose is to provide a means of communicating to the practitioner whether a tiered co-payment would be applied if DHSS policy changes, based on the flexibility allowed with the passage of the Deficit Reduction Act.
POST38	Create the ability to allow a user to enter a health plan name associated with an aid category list, alternative ID, coverage ID, co-pay list ID, and classification ID to support a client's interactive eligibility formulary and benefit information.

Pharmacy ePrescribing Requirements	
POST39	Provide regular updates to the ePrescribing hub based on changes to client data in the MMIS. The information will used to establish uniqueness for clients among the different third-party vendors.
POST40	Provide a client's prescription medication history to the ePrescribing Hub from the MMIS via the NCPDP Script 8.1 medication history transaction. Allow the flexibility for up to 50 paid history prescriptions to be returned to a valid DMAP provider/prescriber. At a minimum, the history should include: the number of prescriptions the client has in history, paid prescription data, and the age of the claims.
POST41	Create the ability for DMAP providers using the ePrescribing facility to access a client's eligibility and PDL information The transaction must comply with HIPAA guidelines and standards.
POST42	Create a report that will capture the eligibility responses sent to ePrescribing hub.
POST43	Create a report that will capture (EVS Hourly Counts) medication history transaction counts.

C.5.2.4 Pharmacy POS Claims Processing Technical Requirements

Pharmacy POS – Claims Processing Technical Requirements	
POST44	Performs online real-time capture and adjudication of pharmacy claims submitted by providers via POS devices, a switch, or through the Internet. Accepts ASC X12N NCPDP claims required by 45 CFR Part 162.
POST45	Returns to the pharmacy provider the status of the claim and any errors or alerts associated with the processing, such as: a. Edit failures b. Pro-DUR alerts c. Member (Beneficiary) or coverage restrictions d. Prior authorization missing e. Required coordination of benefits. f. Refill to soon g. Requires generic substitution h. Deny experimental drugs i. Requires unit dose (or not) j. Package size not approved k. Drug Efficacy Study Implementation (DESI) are not covered
POST46	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 hospice program).
POST47	Verifies that the pharmacy provider is eligible on the date of service.
POST48	Verifies that all fields defined as numeric contain only numeric data.
POST49	Verifies that all fields defined as alphabetic contain only alphabetic data.
POST50	Verifies that all dates are valid and reasonable.
POST51	Verifies that all data items which can be obtained by mathematical manipulation of other data items, agree with the results of that manipulation.
POST52	Verifies that all coded data items consist of valid codes, including NDC for drug codes.
POST53	Verifies that any data item that contains self-checking digits (e.g., Beneficiary ID Number) pass the specified check-digit test.

Pharmacy POS – Claims Processing Technical Requirements	
POST54	Verifies that required data items are present and retained (See SMM 11375) including all data needed for state or federal reporting requirements.
POST55	Verifies that the date of service is within the allowable time frame for payment.
POST56	Verifies that the claim is not a duplicate of a previously adjudicated claim.
POST57	Pays according to the State plan at the lesser of approved pharmacy reimbursement methods, for example: a. AWP minus % + Dispensing Fee b. Federal MAC (CMS Upper Limit + Dispensing Fee) c. Usual and Customary Charges to the General Public d. State MAC (State MAC + Dispensing Fee) e. NADAC f. 340-B
POST58	Create the ability to apply dispensing fees to claims based on taxonomy or type of service (340-B).
POST59	Processes electronic adjustments of paid claims submitted through the Pharmacy POS system.
POST60	Utilizes data elements and algorithms to compute claim reimbursement for claims that is consistent with 42 CFR 447.
POST61	Checks claims against state-defined service limitations.
POST62	Create the ability to checks claims against state-defined service limitations including but not limited to: a. NDC b. GFC c. GC3, or d. A list based on these above referenced categories
POST63	Create the ability to capture the PA number applied to the claim on the claim record
POST64	Deducts Beneficiary co-payment amounts, as appropriate, when pricing claims up to a 30 day defined DMMA limit.
POST65	Deducts TPL amounts, as appropriate, when pricing claims.
POST66	Verifies that the claim is for services covered by the State Plan.
POST67	Verifies that all data necessary for legal requirements are retained.

C.5.2.5 Pharmacy POS Prior Authorization Requirements

The objectives of managing the pharmacy prior authorization processes include:

1. Identifying and recommending specific drugs or classes of drugs as a good candidates for automated prior authorization
2. Notifying clients when drugs for which they have had claims paid in the past may soon require PA
3. Establishing criteria that will evaluate previous and concurrent drug therapies
4. Tracking and reporting reduction realized by new PA categories

C.5.2.5.1 Contractor Business Responsibilities

Pharmacy – Prior Authorization Business Responsibilities	
POSB44	Enter a response in the DMES to a drug PA request within 1 business day.
POSB45	Store all request information electronically and attempt to resolve written and telephone issues related to provider and manufacturer's questions. Faxed or mailed documents will be retained in an electronic document storage and retrieval repository. Criteria requests that can be justified via a telephone conversation will be logged in the DMES notes screen.
POSB46	Work directly with hospice providers to issue PA related to medications that are requested and deemed appropriate, as determined by the State, for a client who has selected this type of care.
POSB47	Review clinical requests for additional nutritional supplements and approve or deny according to State guidelines.
POSB48	Modify and refine the PDL prior authorization processes as agreed upon by the State.
POSB49	Provide support for drug PA process, create criteria that clinical will review and the FA will data enter.
POSB50	Support online criteria forms and interactive PA forms with additions and revisions.

C.5.2.5.2 Contractor Technical Requirements

Pharmacy – Prior Authorization Technical Requirements	
POST68	Interfaces with the pharmacy prior authorization database.
POST69	Demonstrates that there is a field for authorization or identification when an override indicator (force code) is used.
POST70	Interfaces with electronic authorization of health care service transactions required by 45 CFR Part 162, as follows: a. Retail pharmacy drug referral certification and authorization.
POST71	Performs edits to ensure that a prior authorization is present when required.
POST72	Notifies submitter when required prior authorization is missing.
POST73	Create a rules engine with online screen access that will interactively allow the user to build a PA during the adjudication process if needed.
POST74	Create a process to notify clients and practitioners when drug claims previously paid on request may soon or now require PA.
POST75	Create the ability to track and report reductions in volume realized by the new PA categories.
POST76	Create a process to track and report the utilization of progressive or "step therapy" drugs.
POST77	Capture all claims on the Pharmacy Benefit Expenditure Report at the funding source level with aggregate totals.
POST78	Create an automated process for drug prior authorization that interfaces with the Pro-DUR/ECM function.
POST79	Create a process using prior authorization data and/or exclusion for payment of specific drug classes for hospice patients with the Pro-DUR/ECM function.
POST80	Create the ability to individually address and conditionally approve prior authorizations one or multiple edits/audits. A single authorization should not override all edits unless a universal authorization is created.

C.5.2.6 Pharmacy POS Claim Audit Technical Requirements

Pharmacy – Claim Audit Technical Requirements	
POST81	Provides an automated, integrated online real-time Pro-DUR system or provides assistance to the pharmacist to do a prospective drug utilization review.
POST82	Each conflict should have a data element associated with it (i.e., early refill-next fill is available is X days). Drug interaction-conflicting drug is X. High dose-maximum daily dose is X.
POST83	Provides a prospective and concurrent review of prescription practices at the pharmacy and member level.
POST84	Create the ability to perform DUR for HCPCS by applying the same rules applied to the NDC.
POST85	Create a process to identify problems associated with inappropriate drug use and minimally provide inquiring providers online access, to information to include: a. High utilization b. Low utilization c. Early for non controlled d. Early for controlled e. Late refills f. Pediatric usage g. Geriatric usage h. Drugs contraindicated by diagnosis i. Drugs contraindicated by the presence of other drugs j. Incorrect drug dosage k. Drug-to-drug interaction l. Drug-to-therapeutic class m. Level of severity of interaction n. Dose optimization o. Cumulative review for compliance (early refill specifically)
POST86	Identify patterns in the use and cost of drugs by providing drug use profiles, by recipient and provider, and provide inquiring providers online access to information to include items such as: a. Recipient name and ID b. Recipient age and sex c. Nursing home ID d. Inpatient diagnosis codes e. Outpatient/ambulatory diagnosis codes f. Dates of service g. Provider numbers (for example, hospital, pharmacy, physician, primary care) h. Provider type code i. Prescriber ID j. Drug code and description k. Drug strength l. Dosage form m. Quantity dispensed n. Brand certification o. Days' supply p. Prescription number
POST87	Compares the claim against member history and benefit rules to determine if the new claim complies with State standards for: a. Therapeutic appropriateness

Pharmacy – Claim Audit Technical Requirements	
	b. Over Utilization c. Under Utilization d. Appropriate use of generic products e. Therapeutic duplication f. Drug-disease contraindications g. Drug-pregnancy contraindications h. Drug to drug interactions i. Incorrect drug dosage or duration of drug treatment j. Clinical abuse or misuse k. Consistent with patient age l. Consistent with patient sex m. Consistent with refill policy
POST88	Generates alerts (messages) to pharmacy providers as required by State policy including each point of service location.
POST89	Create a process to notify a provider when a denial or alert registers for: a. Alert conflict type, for example a drug allergy alert b. Pharmacy name and number when the conflicting drug alert involves another pharmacy c. Alert severity, such as minor or major d. Remaining available data related to the alert (including prescriber and drugs)
POST90	Provide for denial of claim records and alert the provider where appropriate.
POST91	Allows the pharmacy the ability to override a Pro-DUR alert with the appropriate NCPDP codes.
POST92	Provide the ability to deny claims with Pro-DUR alerts, even with appropriate codes, unless a PA is available.
POST93	Provide the ability to override a Pro-DUR alert with appropriate NCPDP codes and additional NCPDP data elements, such as “clarification code.”
POST94	Maintains user controlled parameters for all standards and messages.
POST95	Create a set of parameters to control and maintain the production of profiles based on category of disease, drug class, or other parameters, including: a. Flag individual recipients and providers as exceptional according to State-specified criteria b. Provide an audit trail of all inquiries, including who made the inquiry, information input, response provided c. Allow providers to provide comments as a response and store all responses d. Generate management-level reports on drug utilization
POST96	At a minimum, meet all requirements for ECM and Pro-DUR detailed in the State Medicaid Manual, Part 11.

C.5.2.7 Pharmacy POS Third Party Liability Technical Requirements

Pharmacy – Third Party Liability Technical Requirements	
POST97	Denies claims for members with appropriate third party coverage or Medicare Part D assignment. In this case, provides insurance information in the POS message along with notice of denial of payment.
POS98	Provide primary insurance information to the provider on any claim rejected for TPL coverage.

C.5.2.8 Pharmacy Drug Rebate Business Area

DHSS supports several rebate programs, in addition to the CMS federal program, there is a SPAP, diabetic supply, Title XXI and encounter collection of rebates.The supplemental rebate program on a guaranteed price philosophy. The supplemental rebates must coordinate with any changes in the CMS unit rebate amount (URA). The Drug Rebate function allows for a manufacturer's covered outpatient drugs to be eligible for federal Medicaid funding under the program, and the manufacturer must enter into a rebate agreement with CMS and pay quarterly rebates to the States. It also allows Labelers to access quarterly drug rebate invoices and claim level details through the use of the secure web site. The system must be able to calculate the federal offset amounts based on paid rebates.

Objectives of the Drug Rebate Business Area are:

1. Produce Drug Rebate Invoices for Drug Manufacturers
2. Process the CMS Rebate Utilization files
3. Process the supplemental URA file
4. Supply Drug Rebate Reporting
5. Allow Online Access to Drug Rebate Data
6. Resolve Drug Rebate Disputes

C.5.2.8.1 Contactor Business Responsibilities

Pharmacy – Drug Rebate Business Responsibilities	
POSB51	Attempt to resolve written and telephone issues related to provider and manufacturer's questions.
POSB52	Develop and maintain documentation related to the PDL and rebate processes, maintain an operations manual, and notify State and call center staff of any revisions.
POSB53	Publish a Drug Rebate calendar and distribute to DHSS financial team to estimate when the billings are sent.
POSB54	Produce Web invoices, providing the data in an electronic format versus paper.
POSB55	The Contractor must be able to provide claim level detail to labelers based on DHSS specifications.
POSB56	Ensure labelers are properly enrolled so the labeler can retrieve invoices.
POSB57	Supply support for printing and mailing rebate invoices as needed.
POSB58	Participate in a multi-state supplemental rebate program or provide a means to acquire aggressive supplement al rebate offers.
POSB59	The PBM must provide routine data exchanges with the entity that has total or supplemental URAs.
POSB60	Contract with manufacturers and maintain State-only rebate contracts.
POSB61	Scan rebate invoices into an electronic document storage and retrieval repository.
POSB62	Resolve federal, State, and supplemental rebate disputes and past due balances and not let the combined amount exceed 200.
POSB63	Assure accurate accounting rebate invoices, receipts, etc. for the State, and contact once a year, each labeler with a 30 days past due balance.
POSB64	Make adjustments to the federal rebate amount, resulting in a reciprocal effect to the Supplemental Unit Rebate Amount (SURA) so the net rebate amount remains the same for the entire year.

Pharmacy – Drug Rebate Business Responsibilities	
POSB65	Update manufacturer information with CMS files and state specific information.
POSB66	Produce, detailed by program, invoices quarterly to accommodate federal, supplemental, state specific, and encounter.
POSB67	Receive and process rebate payments from manufacturers within the financial week.
POSB68	Disposition drug rebate receipts to the DMES.
POSB69	Produce quarterly CMS utilization files within 5 days of creating an invoice.
POSB70	Verify receipt of the data and correct any issues as related to errors in submission.
POSB71	Request the DHSS to issue refunds to manufacturers as the result of overpayments.
POSB72	Assign a pharmacy consultant that will focus on oversight and responsibility for all drug rebate related activities such as invoices, disputes, NCPDP unit conversion, and HCPCS crosswalks.
POSB73	Comply with federal timeliness requirements in all phases of processing.
POSB74	Provide the State with weekly and on-request reports related to the status of rebate accounts receivable.
POSB75	Meet with DHSS on a quarterly basis to review DR operations, provider minutes, and agenda. Examples include Quarterly Schedules of Outstanding Balances for Drug Rebate A/R, and Quarterly Drug Rebate Meeting Minutes.
POSB76	Monitor receivable schedules and providers not responding timely. The PBM will notify DHSS at each quarterly meeting and initiate conversations with CMS should they have to assist in collection from the manufacturer. Quarterly reporting will include at a minimum, producing schedules and listing of the top 10 unpaid invoices.
POSB77	Report monthly the names of the top 10 past due manufacturers.
POSB78	Monitor CMS website daily.
POSB79	Inform DHSS and download data from CMS within 3 days and produce the quarterly invoices within 10 days of CMS posting.
POSB80	Maintain a copy of manufacturer invoices.
POSB81	Answer questions regarding new labelers.
POSB82	Send replacement invoices.
POSB83	Apply all adjustments to the system within 5 days of receiving the Reconciliation of State Invoice (ROSI).
POSB84	Disposition any monies within the financial week received and apply the monies to the assigned invoices based on labeler ROSI.
POSB85	Deposit money within the financial week received.
POSB86	Process prior period adjustments and rebate amounts within 3 days of receipt from CMS.
POSB87	Handle processing interest, when billing adjusting or receiving interest payments, as a separate process; and update the DMES as directed by the State.
POSB88	Follow the prevailing quarterly Treasury Bill rate to calculate interest on late rebate payments.
POSB89	Administer any bankruptcies when a bank notice is received, they must inform the State. The PBM cannot act on providing information; it must consult with the State.
POSB90	Notify DHSS of any unpaid drug rebate accounts receivable that exists after all cash dispositions and ROSI adjustments applied, outlining steps to take to collect balance due or recommend write-off based on DHSS thresholds.
POSB91	Support DHSS in federal or State audits.
POSB92	Track drug rebate activities by manufacturer, including the billing of manufacturers, calculation of interest, and tracking collection of rebates.
POSB93	Support DHSS for pharmacy rebate RFP processes as needed (i.e., diabetic supplies).

Pharmacy – Drug Rebate Business Responsibilities	
POSB94	Review any new labelers for appropriate coverage related to rebate and maintain the information on the DMES.
POSB95	Create quarterly messages, after being reviewed and approved by DHSS, on the banner page for each invoice type.
POSB96	Practice good accounting principles and prepare a GAAP report annually.
POSB97	Have pharmacy limitation edit for repeated disputes.
POSB98	Convert NCPDD units to CMS units and identify NDCs that need conversion.
POSB99	Initiate dispute settlement process for 25% of the disputed invoices excluding the most recent quarter.
POSB100	Prepare weekly summaries of monies received and distribute via email.
POSB101	Distribute W-9 forms as requested.
POSB102	Distribute past due notices at 30-day and 60-day intervals.
POSB103	Prepare dispute settlement documents in favor of the labeler as defined by DHSS.
POSB104	Provide support for the supplemental rebate programs and negotiate the rates.
POSB105	Maintain streamlined criteria from the information presented to the Pharmacy &Therapeutics committee, that meet the program needs to adequately evaluate coverage of non-preferred drugs.
POSB106	Provide downloadable PDL for providers via the DMAP website.
POSB107	Support Pharmacy & Therapeutic (P&T) activity.
POSB108	Update the DMAP website with a full PDL within 10 business days after each therapeutic category has been reviewed.
POSB109	Provide quarterly cost-savings-analysis reports to the State. Cost savings are typically reported for a PDL and associated supplemental rebate program in the following categories: total savings, supplemental rebates and market shift savings.
POSB110	Track the P&T committee membership and recruit new members.
POSB111	Supply presentations to the P&T committee (or other designated entity) and accompanying clinical monographs to the State.
POSB112	Generate a separate quarterly invoice for supplemental rebate amounts. Separate invoicing is a requirement of CMS.
POSB113	Consult with CMS and other states on policy and procedural issues related to drug rebate processing as approved by the State.
POSB114	Be familiar with new and revised federal and State regulations as it applies to the rebate program, and alert DHSS of any impact to the program or to the DMES.

C.5.2.8.2 Contractor Technical Requirements

Pharmacy – Drug Rebate Technical Requirements	
POST99	Flags claims for Drug Rebate processing.
POST100	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, such as: a. Period of time covered b. NDC number c. Total units paid d. Product names e. Number of prescriptions paid f. Rebate amount per unit based on the CMS approved formula or supplemental

Pharmacy – Drug Rebate Technical Requirements	
	rebate g. Unit Rebate Offset Amount (UROA) h. Non-Medicaid paid amount
POST101	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.
POST102	Provides data to support the State in case of a drug manufacturer dispute over the rebate invoice.

C.5.2.9 Drug Utilization Review, Prospective and Retrospective Drug Utilization Review (DUR) Business Area

The combined purpose of the DUR and Pro-DUR programs is to: improve the quality of pharmaceutical care; ensure that prescriptions are appropriate and medically necessary; identify potential drug therapy problems before the drug is dispensed; and to avoid the adverse medical results. The DUR provides an evaluation of prescribing patterns or targeted drug use to specifically determine the appropriateness of drug therapy. In contrast, the Pro-DUR process is a series of alerts incorporated into an online, real-time pharmacy claims processing system. This feature provides immediate feedback to pharmacies regarding the prescription, medical history, and age information of Medicaid clients.

DUR functions include interacting with the Delaware DUR Board, providing call center support and providing a Preferred Drug List (PDL), as well as physician notifications and the addition of new drugs to prior authorization procedures.

The Retrospective Drug Utilization Review (Retro-DUR) Business Area monitors historical paid claims data to identify patterns of inappropriate medication use by clients, pharmacists, and prescribers. Trend analyses from Retro-DUR can decrease unnecessary expenditures by providing post-payment utilization data and intervention upon discovery of inappropriate patterns of drug use.

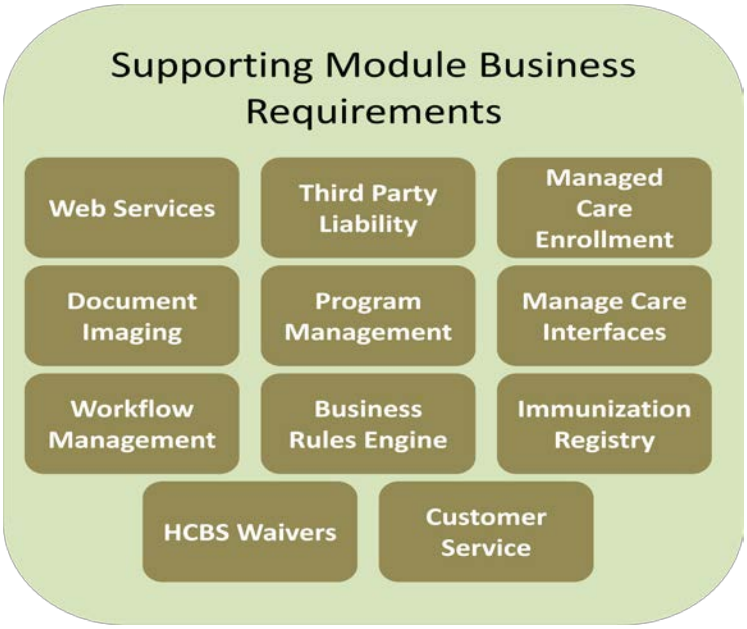
Objectives of the Drug Utilization Review Business Area are:

1. Maintain Pharmacy Call Center staffed with Pharmacy Technicians.
2. Provide access to up-to-date PDL.
3. Tracking and reporting the utilization of progressive or “step therapy” drugs and the optimization of drug dosages.
4. Capturing, maintaining, or passing diagnosis and disease profile information.
5. Providing pharmacists and pharmaceutical personnel sufficient to aggressively and effectively intervene and resolve drug disputes with prescribers and pharmacies.

Pharmacy – DUR Technical Requirements	
POST103	Generate prospective and retrospective data for DUR with monthly updates and summaries provided at the FFY level to support the completion of the CMS annual report.
POST104	Develop provider profiles with comparisons with peers.
POST105	Provide electronic access to test data (pharmacy and recipient claim information) for use in determining sensitivity level for both retrospective and prospective DUR criteria.

Pharmacy – DUR Technical Requirements	
POST106	Create the ability to produce emails and letters for purposes of focused educational and report card type interventions based on retrospective DUR to both providers and recipients.
POST107	Establish and maintain therapeutic criteria files for therapeutic exception criteria that can be used to identify specific pharmaceutical use problems. The therapeutic criteria files must have quantitative significance values or severity ratings that may appear on patient-specific alert reports.
POST108	Create the ability to suppress patient profile generation for previously identified criteria, after initial flagging, for a period specified by the State.
POST109	Create the ability for DUR reports to be user programmable.
POST110	Create the ability to compare reports for month-to-date and year-to-date totals.
POST111	Create the ability to run a report for a user-defined period of time.
POST112	The module must retrieve information and produce outputs which support the creation of: a. Monthly summary reports that include a count of patients whose profiles are being flagged for the current month, a listing of patient names and numbers, and a listing of all drugs that caused profiles to be generated b. Specific patient drug history reports which includes a chronological listing of all drugs being taken and summary the number of providers involved in a patient's therapy c. A drug therapy assessment report d. A report of intervention responses e. Outcome assessment reports as defined by the State f. A report that identifies drug claim records paid that are not appropriate for current primary or secondary diagnosis g. Reports for a user-defined time frame h. Reports on the cost savings from Retro-DUR i. Retro-DUR reports of all pharmacy claim records utilizing recipient, provider, claim records, and encounter data information j. Reports based on pharmacy and physician criteria including NDC numbers, generic drug codes, or therapeutic classification codes of drugs and specific ICD-9 and the quantities prescribed by a specific physician or filled by a specific pharmacy k. The annual DUR report for submission to CMS
POST113	Create the ability to retrieve data through the online reporting function to generate the following necessary outputs and support the following Pro-DUR information needs: a. Annual reports required by CMS b. Report listing all Pro-DUR alerts by type c. Reports to the DUR Board for review of output and approval of corrective actions d. Cost savings e. Therapeutic categories f. Interventions and outcomes g. Recipient with a threshold level h. Management reports i. Updated parameter data set j. Make all reports available in online reporting system and using other media as specified by the State

C.5.3 Supporting Modules and System Components outside the Core



C.5.3.1 Web Services (DMAP Website)

The FA maintains the DMAP website as part of the EVS and is where secure interactive access and non-secure inquiry is available to Delaware providers, clients, and others. The DMAP website non-secure area contains information and links to other pertinent websites, downloadable form and manuals, and a link to the secure provider area of the website. Providers with security access are able to check on client eligibility, claim status, prior authorization status, payment status and other inquiries.

Objectives of the DMAP website are to:

1. Make available most current Provider Manuals
2. Maintain Eligibility Verification capability
3. Provide downloadable forms
4. Provide PA processes
5. Provide access 24x7, both secure and non-secure, to DMAP website
6. Provide a secure and reliable web service portal for DHSS to support Medicaid
7. Implement web processes to support claim data adjudication for defined services, policy, and payment parameters
8. Provide for the timely disposition of prior authorization requests.
9. Implement a system that supports effective communications with providers, beneficiaries, and the public (CMS 7.5)
10. Comply with federal, state, and industry regulations

11. Employ an open, reusable system architecture that separates the presentation layer, business logic (i.e., service layer), and data layer for greater flexibility, security, performance, and quality of design, implementation, maintenance, and enhancement in the software life cycle
12. Develop interfaces as part of a service-oriented architecture (SOA) (CMS 7.1)
13. Provide an automated provider enrollment process using a web-based application

C.5.3.1.1 Contractor Business Responsibilities

Web Services Business Responsibilities	
WSB1	Provide DMAP website availability 24x7.
WSB2	Provide user support for DMAP website.
WSB3	Maintain the most current and up-to-date provider manuals on the DMAP website in downloadable format.
WSB4	Allow providers to inquire on check-write information from the most recent payment cycle.
WSB5	Maintain online PA creation, inquiry, and update.
WSB6	Complete additions and/or updates to the web portal that do not require functionality change(s) within 2 days from the DHSS request.
WSB7	Update the Frequently Asked Questions (FAQ) section of the web portal within 2 days of receipt of the DHSS approval.
WSB8	Obtain approval by the DHSS for all documents (e.g., applications, manuals, handbooks, notices, welcome packets, and others), before posting on the web portal.
WSB9	Provide information and links to federal and State policy, as well as supplemental information on Medicaid and other services approved by DHSS for current and potential providers and clients.
WSB10	The Contractor must immediately post banner messages or alerts informing the users of the resolution of the technical issues.
WSB11	In the event of unscheduled downtime, the Contractor must immediately notify DHSS of the downtime with a plan of action to remedy to problem, including a time when the system is expected to be available. Unscheduled downtime will be followed by an impact statement that documents the issue, resolution, and mitigation plan to prevent future occurrences and improve resolution time if the event occurs again.
WSB12	The Contractor must formally notify and request approval from DHSS prior to scheduled system downtime. Request will include reason, duration, and potential impacts.
WSB13	The Contractor will provide weekly reports to DHSS detailing all system downtime.
WSB14	Update the DHSS website with a full PDL within 10 business days after each therapeutic category has been reviewed.
WSB15	Upload all previous documents that are on legacy website to new Web Portal.

C.5.3.1.2 Contractor Technical Requirements

Web Services – Technical Responsibilities	
WST1	Develop and implement a system Web Portal to support response times that must be within 4 seconds for 99% of the time.
WST2	Create and maintain a process for archiving posted announcements, banner messages, and non-provider specific alerts including the effective date of the notification and actual message text.
WST3	Create the ability to link uploaded documents or images to other system

Web Services – Technical Responsibilities	
	documents/images/cases.
WST4	Provide the capability for the appropriate users to query audit history by data element, user profile, user ID, client ID, or Provider ID, data exchange type within a date and time range.
WST5	Create the ability to upload electronic documents or images in a variety of formats (e.g., PDF, PNF, JPEG, TIFF, and GIF) and sizes greater than 20MB. Types of electronic files include medical images (digital X-rays, MRI, ultrasounds, etc.).
WST6	Create a process for the general public to report suspected Fraud, Waste and Abuse via Web Portal.
WST7	Provide the capability to exchange web portal data elements by standardized web services to support applications as identified by DHSS.
WST8	Create and implement an automatic log off control feature for registered users after a set amount of time expires as defined by DHSS. A warning message must be displayed prior to session timeout.
WST9	Provide an online tutorial functionality
WST10	Provide Computer Based Training (CBT) through the web portal for providers and their offices for the purpose of learning. Audit trails will be maintained for those utilizing the CBT sessions. Provide required training statistics to DHSS.
WST11	Create and maintain versioning control, and search capabilities for documents use by authorized users.
WST12	Provide a process to create an audit trail and history of all transactions conducted on the Web Portal and send data to the DSS/DW, as determined by the DHSS.
WST13	Create the ability to log, track, and transmit supporting documentation entered into the web portal to the Provider Management Module of the MMIS, or other modules, such as PA, as needed or directed by the DHSS.
WST14	Create a process to allow clients and providers to register online for access to the secure areas of the portal and provide ability to change and/or reset password via the portal.
WST15	Create a Provider privacy policy page on the DMAP website.
WST16	Create a Client privacy policy page on the DMAP website.
WST17	Allow clients the ability to review active Medicaid providers (e.g., dentist, lab, pharmacy, behavioral health, etc.) by selecting one or more inquiry criteria including: name, location, provider type, and specialty type. The web portal should return results to the client that include name, office location(s), office hours, contact information, and specialty type for each provider found matching the search criteria. From the results page, users should be able to click to get a map to a provider's office.
WST18	Allow clients to view their coverage, benefits, and member requirements including PDL, co-pay requirements, drug benefit policy (i.e., generic vs. brand, step therapy, etc.) on the web portal.
WST19	Allow clients and head of household to receive health guidance (periodic check up schedules, immunization schedules, pregnancy guidance, etc.) through the portal.
WST20	Allow clients and head of household to receive reminders and alerts through the portal for health guidance (e.g., smoking cessation classes, Health workshops), assessment completion, upcoming or overdue healthcare, and open enrollment.
WST21	Provide links where appropriate to services providers (e.g., Non-emergency transportation broker) and DHSS program information (e.g., Money Follows the Person (MFP) and Dental care).
WST22	Allow clients to link reminders and alerts to their email address.
WST23	Allow clients and head of household to complete, save, and return healthcare assessments via the web as recommended by case managers.

Web Services – Technical Responsibilities	
WST24	Create and maintain a DMAP Frequently Asked Questions (FAQ) section on the website.
WST25	Provide users with access to appeals procedures on the web.
WST26	Provide users with access to client rights and responsibilities on the web.
WST27	Integrate the client web experience with the services and information provided on the clients selected managed care organization website.
WST28	Allow clients and head of household to review client rights and responsibilities.
WST29	Provide a method for clients to review claim status and payment details in an explanation of benefits (EOB) document.
WST30	Provide a method for clients to view authorized services.
WST31	Provide clients the ability to change PCP, change MCO when appropriate, update other insurance, request ID cards, and Request Certification of Coverage through the web portal.
WST32	Create a process to allow the DHSS to identify items for monitoring. Items may be automated operations on the web portal or manual actions.
WST33	Provide the capability to handle, through the web portal, at least 20,000 users nationally at one time.
WST34	Create the ability to allow an authorized administrative user account to be created within a provider practice to activate, deactivate, and assign varying levels of access to additional practice staff, not to exceed the authorized administrator level of access.
WST35	Provide multiple levels of security, as designated by the DHSS.
WST36	Allow account access privileges to be limited to specific service or taxonomies but not solely limited to this.
WST37	Allow user accounts to be attached to multiple provider NPIs to allow access to the data pertaining to multiple providers within one session.
WST38	Create a web services portal with single sign-on security to access the services and functionality provided.
WST39	Create the ability to query and display the current and historical client eligibility information, including aid code, TPL, managed care enrollment organization, lock-in status, program limitations and service limits exhausted by a client on the DMAP website to providers and other users authorized by the DHSS.
WST40	Create the ability on the provider web portal to allow providers to view current claims status including pending claim billed amount and payments scheduled for the upcoming pay period.
WST41	Provide access to claim payment history for the past quarter at minimum. History response information should include all RA data.
WST42	Allow providers to sign up for DMAP electronic mailing lists by topic.
WST43	Create the ability to allow a provider to check the status of their Medicaid provider enrollment application, regardless of the method used to submit the application.
WST44	Create a process to allow providers to sign up for Electronic Fund Transfer (EFT).
WST45	Allow providers to enter whether they are accepting new patients, whether they are accepting Medicare patients, and other designations, as directed by the DHSS.
WST46	Create the ability to allow a DHSS provider to download application forms, bulletins, manuals, forms, and lists from the web portal.
WST47	Create the ability to receive and respond to eligibility inquiries via a web portal in real-time, using both a standard browser protocol and a hand-held device protocol using standardized web services
WST48	Create the ability to allow users online to request: claim detail reports and show all claims, adjustments, and financial transactions that have occurred within the period for

Web Services – Technical Responsibilities	
	the selection parameters requested.
WST49	Create the ability to process direct data entry of provider claims real-time via the web portal and reject claims that fail front-end edits.
WST50	Create the ability to accept electronic claims batches uploaded via the web portal.
WST51	Provide the capability to accept all claim types, corrections, and voids and replacement claims through direct data entry on the web portal.
WST52	Create an automated process to check for duplicates when a PA is entered and based on DHSS parameters allow for auto-rejection, review for suspected duplicate, or approval of the PA (addendums and PA updates are not duplicates).
WST53	Create the ability to allow authorized providers to directly data enter and submit PA requests, PA addendums, and updates to PAs on the web portal.
WST54	Create the ability for providers to request the status of prior authorizations for a date or date range and/or by procedure code, for a Client, through the web portal.
WST55	Create a process that will provide a systematic reply and decision on the request for: prior authorization, addendum, and/or updates at the time the request is data entered into the web form, when appropriate.
WST56	Allow authorized users to query and view prior authorization status by PA number, provider number, or Client Medicaid ID.
WST57	Create process to be compliant with CMS release #154 for providing specific drug rebate electronic invoicing via email to manufacturers.
WST58	Create the ability to produce Drug Rebate invoices with NDC level detail, providing the data in an electronic format for retrieval via the web.
WST59	Create a process for publishing PDL information through the DMAP website.
WST60	Create and maintain the ability to allow providers to search National Drug Codes, label or generic names on the DMAP website, and include drug status and reimbursement level.
WST61	Provide a downloadable PDL for providers via the DHSS website.
WST62	Create the ability to post announcements or alerts that are displayed at user sign-on. Users should be required to acknowledge the announcement so that it is not repeatedly displayed at subsequent sign-on.
WST63	Provide the ability to create and process online surveys designed by DHSS or the Contractor: a. Allow for a variety of styles for the look of a survey b. Provide for quick and simple deployment of surveys as authorized by DHSS c. Allow for email responses d. Provide secure “Once-only” responses e. Provide security for the survey and responses f. Provide survey results and feedback to DHSS g. Tabulate the results of each survey and present in chart or graph format h. Provide accessibility to response data as a file that may be imported to Excel or other applications i. Allow for responses to be viewed using pie charts, bar graphs, and in other ways j. Support reporting features that will allow for response data to be tabulated by number
WST64	Create the ability to allow providers to submit client insurance coverage information via the web and attach to the correct client record.
WST65	Create and support, at the user level, the ability to receive and respond to secure and HIPAA-compliant emails from providers, beneficiaries, other contractors, and the DHSS staff.

Web Services – Technical Responsibilities	
WST66	Create the ability to post banner messages or alerts to users when the MMIS is experiencing technical issues that prevent users' ability to perform tasks.
WST67	Create a process to "blast" messages to all providers, selected providers, or selected provider types via email address.
WST68	Create provider specific and user specific online report retrieval capabilities, including printing of the provider's 1099.
WST69	Create and maintain an interactive troubleshooting engine for possible or identified web service issues, such as common error message received in forms completion. If issues could not be resolved, direct user to the appropriate person, such as Provider Rep for Providers, and Contractor for the DHSS via some type of notification, as defined by the DHSS.
WST70	Create a process to allow web portal users to contact provider relations and helpdesk staff. The user must receive a confirmation message or number when submitting a request.
WST71	Provide ability to create, modify, access, and store treatment plans by providers via the web portal.
WST72	Support receipt and storage of attachments (e.g., medical records, radiographs, and digital orthodontic files) submitted in support of PA requests, including addendums and updates to PAs.
WST73	Create the ability to allow users to view and print provider manuals, instructions, bulletins, program descriptions, eligibility criteria, and forms.
WST74	Create a process to accept provider disclosure statements via the web (including newly enrolling providers and as required) and suspend and terminate providers who fail to submit the disclosure or submit disclosure information that fails to meet DHSS requirements. Continue to allow suspended providers to submit a disclosure prior to termination.
WST75	Develop a mechanism to collect fee schedules from individual physicians and dentists and suspend providers who do not submit the appropriate schedules.
WST76	Develop an automated, regular process to post suspended providers that have a SUR sanction, fraud conviction, or administrative action on the DMAP website.
WST77	Develop a process to allow provider to enroll with DMAP via the Web portal and track enrollment progress.
WST78	Identify web applications for which required provider enrollment paper documents have not been received and auto-generate a resolution letter and/or email to the applicant.
WST79	Inform applicant of enrollment progress, disclosure progress, and events that require their attention via email.
WST80	Host DHSS provider fee schedules online in a DHSS designated downloadable format. Update fee schedules as directed by DHSS.
WST81	Comply with all standards adopted by the Secretary under Section 1104 of the Affordable Care Act.
WST82	Comply with all standards and protocols adopted by the Secretary under Section 1561 of the Affordable Care Act.
WST83	Create and support the ability to use electronic signatures in compliance with DTI standards.
WST84	Employ an open, reusable system architecture that separates the presentation layer, business logic (i.e., service layer), and data layer for greater flexibility, security, performance, and quality of design, implementation, maintenance, and enhancement in the software life cycle.

Web Services – Technical Responsibilities	
WST85	Provide navigation clues (i.e., bread crumbs) for the user as a way to keep track of their location within programs or documents.
WST86	Provide hotlinks to frequently visited areas of the fiscal agent website at the DHSS request.
WST87	Provide browser-based screens with point-and-click and hover capabilities.
WST88	Post Frequently Asked Questions (FAQs) online, organized by topic or key word search, and update periodically, and as determined by the DHSS.
WST89	Interface with the NLR to exchange applicant information related to the HITECH EHR Medicaid Provider Incentive Program payments.
WST90	Allow providers and SMHPO users secure access to the Provider Incentive Payment system through the Internet (secure MMIS provider portal).
WST91	Allow state Medicaid providers (Professional and Hospital) to register, apply for, and view their incentive payment information.
WST92	Allow providers to print their application (attestation, information from the NLR, contract information).
WST93	Provider will be able to save, alter and come back to their applications at any time up to the point of submission.
WST94	Provide “hover” bubbles for certain data to provide additional information regarding the information the provider is asked to enter and/or confirm.
WST95	Provide links to information or instructions that will assist the user in completing the online application.
WST96	Display Provider Identification information (NPI, TIN, Payment Entity) at the top of all screens and printed pages to provide clarity to the provider and user.
WST97	Provide a “Progress Bar” will display remaining percent or a graphic depiction of how much is left to complete.
WST98	Provide a "back" button along with other standard navigation features only until the application is finished and submitted. At completion, the provider will be able to navigate, view, and print or download to a PDF (finished), but not alter the data.
WST99	Support the completion of required fields before allowing the provider to proceed to the next field.
WST100	Include a “Contact Us” functionality to allow providers to send incentive program information request emails to a Provider-Call Center mailbox.
WST101	Support all NLR interface files including the CHPL verification of certified EHR systems.
WST102	For internet-facing web applications, there must be a Spanish language option at the logon screen for users to choose in order to display a Spanish language version of the application. Contractor will be responsible for any translation services necessary and must include an estimated cost for this in their proposal.
WST103	Web applications must also demonstrate substantial W3C compliance for accessibility and standardization purposes.
WST104	Web applications must compatible with/support web page text to audio speech applications.

C.5.3.2 Document Imaging, Storage and Retrieval

The Document Imaging System supports the activities and workflows of DMES users by providing access to electronic versions of documents and reports. Document Imaging provides a central image repository for incoming and outgoing faxes, emails, claims, correspondence,

and supporting documentation. It facilitates the routing, review, and sharing of documents among a large user group without the risk of paper loss or destruction.

The Document Imaging System is divided into four functional processes:

1. The Document and Imaging System first requires all designated items to be imaged using Contractor-supplied software.
2. The Document Imaging Capture process includes the gathering of scanned documents (claims and correspondence), electronic faxes, management reports, select emails, outgoing letters and statements, and other document attachments.
3. The Document Imaging Storage process encompasses the retention of captured documents and reports to provide viewing access and archival capabilities for all stored information.
4. The Document Imaging Retrieval process provides end-user viewing capabilities for the stored electronic documents and reports.

C.5.3.2.1 Contractor Business Responsibilities

Document Management – Business Responsibilities	
DMB1	Operate the document management component of the DMES, including Improvements and enhancements as they are implemented.
DMB2	Support the central repository and document management tool that captures, stores and indexes documentation received by the DMES.

C.5.3.2.2 Contractor Technical Requirements

Document Management – Technical Requirements	
DMT1	The document management system should support and store, at a minimum, the processing of: a. Agreements b. Paper claims c. Claims adjustment forms d. Pharmacy PA forms e. Completed provider enrollment forms f. State and Contractor correspondence g. PL correspondence
DMT2	Store data in a central repository.
DMT3	Create the ability to access, through the use of an index, stored, system-generated beneficiary and provider notices.
DMT4	Destroy source documents according to procedures defined by the DHSS.
DMT5	Create the ability to image, store, and retrieve, upon demand, all correspondence and documents associated with a provider's record.
DMT6	Create the capability to convert data contained in images into MMIS data through Optical Character Recognition (OCR).
DMT7	Create the ability to validate data captured from specific fields on forms electronically read by industry standards, Intelligent Character Recognition (ICR)/Optical Mark Recognition (OMR) /Optical Character Recognition (OCR) - OCR/OMR/ICR.
DMT8	Create the ability to send and receive faxed and secure encrypted e-form documents, process the data and image directly into and out of the system, including the ability to automatically send confirmation of transmission to the sender.

Document Management – Technical Requirements	
DMT9	Create the ability to determine if a designated field on a specific form contains a required signature (i.e., field is not left blank).
DMT10	Create the ability to scan radiographs and diagnostic images.
DMT11	Link scanned images to workflow records to provide one view of all related material (e.g., images, letters, interactions, and tracking number).
DMT12	Create the ability to send data from scanned, imaged, and released claims to the MMIS in real-time.
DMT13	Through the system user interface, create the ability to view, at a minimum: highlighting, image rotate, zooming, and set-up options capabilities.
DMT14	Create the ability to reject items in the system for incompleteness during upfront processing, and generate a letter with address insertion, and a hard copy of the image for mailing to the submitter. This function must be capable of maintaining data to generate ad hoc reports with statistical information, such as how many claims are returned to a specific address, or within a user specified time period.
DMT15	Create the ability to allow the user to manually remove, rescan, and replace a scanned image or document(s) from a previously scanned group of documents.
DMT16	Provide equipment that is Open Document Management Architecture (ODMA) compliant to accept scanned images from any DHSS equipment.
DMT17	Provide simplex and duplex scanning capabilities on a user-defined basis, by document type.
DMT18	Provide advanced Optical Character Recognition, Intelligent Character Recognition, and Optical Mark Recognition capabilities of 90% accuracy rate or higher, and the ability to regulate the error percentage, by document type, between 90% and 100%.
DMT19	Provide scanning software that is programmable to accommodate user-defined field edits, such as the exclusion or inclusion of special characters (e.g., exclusion of the decimal point in diagnosis codes, inclusion of decimal point in currency).
DMT20	Provide scanning software that has virtual rescan capabilities that will auto correct a skewed document within 20 degrees, and automatically adjust document resolution at a minimum of 300 dpi.
DMT21	Provide the capability of linking resubmitted paper claims or supporting documentation to original scanned (pending) claims, including the ability to recognize a duplicate claim; and generate a notice to the defined user that an identical claim has been previously processed.
DMT22	Provide the capability to attach notes, annotations, emails, and other documents, to an original scanned document at any time, without rescanning, by direct system access (users) and end users.
DMT23	Provide the ability to recognize and automatically delete blank pages without storing them in the system.
DMT24	Create the ability to auto set field characters to upper case, lower case, or ignore case, as defined by the user.
DMT25	Create the ability to scan documents, which vary in size, texture, and color. The system must accept documents of all sizes, paper weights, and colors, as identified as industry standards for imaging or printing.
DMT26	Provide the capability to group documents together during scanning, based on document type or a predefined number of documents set by the user.
DMT27	Include a high-speed imaging solution capable of imaging documents and automatically routing documents.
DMT28	Utilize platforms that will enable workflow, document imaging and management, and e-forms.
DMT29	Create the capability to automatically orient forms to landscape or portrait presentation.

Document Management – Technical Requirements	
DMT30	Create the ability to handle multiple types of letters, forms, publications, and other DHSS designated documents.
DMT31	Provide a documentation management methodology that will support tracking changes to the documentation, an audit trail for changes, and a method to provide documentation changes for approval prior to updating.
DMT32	Create the ability to recognize and read bar coded information for the purpose of extracting data from a barcode, to pre-populate index values, and updating a tracking database.
DMT33	Provide the capability of recording user identification, or user sign-on and workstation identification, to each document processed, accessed, or updated on the system.
DMT34	Provide the ability to log every step in the process to a database, for query and reporting purposes (e.g., employee production reporting, identification of low confidence areas).
DMT35	During the character correction process, create the ability to log, at a minimum, the following statistics: raw recognition rate, characters questioned, characters corrected, beginning operator time, ending operator time, operator ID.
DMT36	Provide access to data through user friendly systems navigation technology and a GUI using pull down menus and point and click technology. In accordance with the new NPRM (file code CMS–2346–F, the new system should provide optimal interoperability and direct data standard transfer by avoiding passing data from existing screen displays to server or PC based applications to reformat the data in a Windows environment.
DMT37	Create a unified content management solution with versioning capabilities and appropriate change control, using appropriate industry standard technologies. This also includes converting and transferring all existing documentation to the DMES, as well as replicating existing interfaces from the MMIS to the converted documentation.
DMT38	Integrate and automate document management and records management at each point in each of the DHSS's existing and new processes.
DMT39	Create a methodology to maintain online historical information by establishing query protocols and standards i.e., by recipient ID number, name or partial name, date of birth, and/or Social Security number (SSN), provider NPI.
DMT40	Create the ability to access the database to extract data to pre-populate index fields, and/or values on forms (e.g., the system would capture the provider identifier and then, using that number, extract the provider's name, address and other information from the provider database).
DMT41	Create online retrieval and access to documents and files, at a minimum of 10 years rolling. Certain documents will be retained online forever (i.e., lifetime procedures, mental health services), as defined by the DHSS.
DMT42	Contain a collaborative document management environment that will allow electronic files (e.g., Word documents, Excel spreadsheets) to be shared, collaborated upon, electronically signed, managed and controlled.
DMT43	Provide the ability to view a document, and all pages within the document, by using a paging function.
DMT44	Provide multiple search options (e.g., Structured Query Language (SQL), various index search options, content based searches, etc.) to view contents.
DMT45	Create the ability to employ user-defined indexes and/or field values for recognition and retrieval of forms.
DMT46	Provide the ability to assign unique document identification numbers, determined by the user, with the ability to prompt the user when a duplicate document identification number is assigned; allowing the user to decide whether to use the previously assigned document identification number or assign a new number.
DMT47	Form Index fields must be user-definable and recognize numeric, alphanumeric, date,

Document Management – Technical Requirements	
	currency, and special characters, as designated by the DHSS.
DMT48	Create ability to process electronic claims attachments. The system needs to be able to link the attachment to the claim and allow the attachment to be viewed online.
DMT49	Provide the ability to differentiate between forms and attachments, and allow the attachment to be grouped with the form to create a single document with individually numbered pages.
DMT50	Provide the capability to store both electronic and imaged paper documents, and make them available online through a single user interface, to promote a total view of current and historical information. Images must be hyperlinked to the appropriate data elements.
DMT51	Provide the ability to view related images from appropriate DE Medicaid Enterprise screens using hyperlinks. The DHSS will determine the subset of images that will be displayed on each screen.
DMT52	Provide the capability to manage document content and configuration across the DE Medicaid Enterprise, with suitable role-based permissions.
DMT53	Support the management of documents created in applications, including, but not limited to: a. Microsoft Word b. Microsoft Excel c. Microsoft PowerPoint d. Microsoft Project e. Text f. Tagged Image File Format (TIFF)
DMT54	Support drag-and-drop functionality, to be used when creating or editing a document.
DMT55	Provide the ability to print or fax one or more selected images from image search.
DMT56	Provide the ability to associate related documents, such as claims and supporting attachments, including the ability to accept more than one attachment for a claim, and identify the primary/correct/current attachment to be used for processing.
DMT57	Provide the ability to relate separate documents to a common set of rules, including workflow rules, either at the time the documents are scanned, or at a later date, from the image search results screen.
DMT58	Include, at a minimum, the following document management capabilities: a. Concurrent retrieval functions to publications and other stored documents b. Automated inventory control for all forms, letters, publications and other DHSS-designated documents c. Storage of documents and files d. Ability to generate documents in both hard copy and electronic format, including forms and letters
DMT59	Provide conversion of all documents to a format as defined by the DHSS.
DMT60	Provide the ability to utilize document management capabilities for scanning and routing documents between regional offices and the DHSS office.
DMT61	Support cataloging/indexing of all imaged documents.
DMT62	Include industry standard Intelligent Character Recognition (ICR) technology, including Optical Character Recognition (OCR), which minimizes manual indexing, and automates the retrieval of scanned documents.
DMT63	Provide the capability to adjust scan preferences for each document type, to include, at a minimum: a. Resolution b. File numbering c. Storage location

Document Management – Technical Requirements	
DMT64	Include, at a minimum, the following imaging and document management capabilities: a. Scan both single and double sided documents b. Scan complete or scraped documents c. Scan color, black and white, and grayscale images d. Support special characters e. Support a wide range of compression methods f. Retrieve images through the use of any OCR/ICR field search g. Retrieve images by ICN/TCN h. Retrieve images by provider number i. Retrieve images by beneficiary ID number
DMT65	Provide the capability to manipulate images, to include: a. Rotation b. Inversion c. Zoom d. Brightness/contrast e. Crop/Cut/Copy a portion of the image
DMT66	Utilize imaging/document management technology that handles multiple types of letters, forms, publications, and other DHSS designated documents and files, and automates workflow processing, to include, but not be limited to: a. Provider enrollment materials b. Claims forms and attachments c. PA forms and attachments d. Coordination of Benefits (including casualty) e. Estate recovery f. Provider correspondence g. Beneficiary correspondence h. Web Portal correspondence i. Beneficiary enrollment materials j. Notices k. Letters l. Audit materials m. Other documents, as defined by the DHSS
DMT67	Allow manual data entry from scanned documents, if they cannot be read, and transmit electronically from an image to the DHSS Enterprise.
DMT68	Employs an electronic tracking mechanism to locate archived source documents or to purge source documents in accordance with HIPAA security provisions.

C.5.3.3 Workflow Management Business Area

The objectives of the Workflow Management Business Area are:

1. Provide an automated, user-configurable workflow mechanism that is able to respond to organizational and business process changes on an ongoing basis. The DMES must provide complete compliance with State and federal regulations

2. Ensure trustworthiness and provide adequate security of non-public information and records.

C.5.3.3.1 Contractor Business Responsibilities

Workflow Management – Business Responsibilities	
WMB1	Document and maintain definition and modeling of workflow processes and their constituent activities in a Workflow Management Module.
WMB2	Support and assist the DHSS in mapping all business processes and sub-processes to the workflow application, and in transitioning from manual to automated process execution.
WMB3	Provide support and coordination of interactions between the workflow engine, and participating DHSS staff, to manage the work required to execute a process, including, but not limited to: a. Work queues for each participating staff member b. Alerts to the presence of work c. Other triggers, timers, and alerts to support workflow d. Status indicators to mark work in progress or completed
WMB4	Provide supporting supervisory operations for the management of workflow, including, but not limited to: a. Assignments/re-assignments and priorities b. Status querying and monitoring of individual documents and other work steps or products c. Work allocation and load balancing d. Approval for work assignments and work deliverables via a tiered approach e. Ability to take necessary action or provide notification when corrective action is needed, including the ability to modify or abort a workflow process f. Monitoring of key information regarding a process in execution, including, but not limited to: 1. Estimated time to completion 2. Staff assigned to various process activities 3. Any error conditions g. Overall monitoring of workflow indicators and statistics by sub-process, organization, or individual staff members, including, but not limited to: 1. Work in queue by priority 2. Throughput 3. Individual and organizational productivity 4. Current activity by individual staff member
WMB5	Assist the DHSS with configuring reporting components to monitor operational activities, including, but not limited to: a. Status of operational activities b. Statistical reporting of receipts and completed activities by process c. Reports of current inventories d. Reports by unit and worker, where appropriate
WMB6	The Contractor shall set up and maintain the new workflow management module and analyze each Division to see how the DMES can be used by them, train the DHSS staff, and be available for new training and questions.

C.5.3.3.2 Contractor Technical Requirements

Workflow Management – Technical Requirements	
WMT1	The system shall be capable of integrating with a Rules Engine as a service in an SOA environment.
WMT2	Create automated workflow management capabilities for routing, reviewing, tracking &

Workflow Management – Technical Requirements	
	updating.
WMT3	Create the ability to perform conditional routing by an authorized user to modify existing forms/documents that may be incomplete or contain errors.
WMT4	Create the ability to configure work distribution, and re-distribution, based on work type, worker skill level, priority, and age of work.
WMT5	Create the ability to configure work distribution rules, using configuration tables managed by the DHSS.
WMT6	Create the ability to employ logic to edit claim data and suspend a claim(s) for manual review by routing the claim to a work queue, mailbox and or inbox.
WMT7	The system must be capable of using business rules for automated work distribution of requests and inquires to designated work queues.
WMT8	Create the ability to automatically schedule and distribute work to individual staff members by work type or other algorithms defined by DHSS.
WMT9	Create the ability for authorized supervisors to override the automatic distribution and distribute work manually.
WMT10	Create the ability for a user to return and insert a work item into the next sequential step of a workflow if a step has been manually by-passed in the workflow pattern.
WMT11	The system must have the ability to inform user when a task or process in a preceding workflow is completed.
WMT12	The system must have the ability to associate a business process to the actual work management process.
WMT13	The system must have the ability to allow authorized users to prioritize work items within each type and/or each category.
WMT14	Create the ability to mirror DHSS's existing workflows and be able to support & provide functionalities for future needs.
WMT15	Create the ability to set up and modify workload distribution to manage workloads on an as needed basis.
WMT16	Create the ability to store and reuse user-defined templates that support various workflow processes.
WMT17	Provide the ability to incorporate simple, low-level workflow processes into more complex, higher-level workflow processes.
WMT18	Create the ability to support workflow management for multiple simultaneous processes, each with multiple simultaneous instances of execution.
WMT19	Create the ability to query the workflow process management system database.
WMT20	Create the ability to manage work assignment using multiple levels of criteria including, but not limited to: characteristics of the claim or PA record (e.g., aging), characteristics of the client (e.g., alphabet of last name), type of claim submission, and edit/audit type.
WMT21	Create the ability to support automated workflow management and distribution of PA requests for medical review and determination.
WMT22	Create the ability to allow authorized users to define workflows that control who and when (sequence) business processes are performed (e.g., provider enrollment workflow, claim processing workflow, prior authorization workflow).
WMT23	Create the ability to enter notes, unlimited in size and number, within the Workflow Management system.
WMT24	Create a process to ensure that notes have a date/time stamp and identify the user entering the notes.
WMT25	Create the ability to assign a note type or category to help users in searching for notes related to a specific event or topic.

Workflow Management – Technical Requirements	
WMT26	Create a process using a table-driven system to search notes by type or category. The tables must be user-maintainable.
WMT27	Create a process to designate certain notes as confidential and restrict access to notes to authorized users.
WMT28	Create the ability to produce status reports and processing statistics.
WMT29	Ability to integrate electronic transactions into a single workflow.
WMT30	The workflow system must allow users to configure performance and reporting functions for, at the minimum, the following activities: a. Status reports b. Customizable aging reports c. Staff loading d. Backlog monitoring e. Processing throughput statistics (items in each stage of process, new items, completed items) f. Statistics regarding time intervals spent on each step, including "idle-time" g. Comparisons for performance measurement, resource planning, and business process restructuring h. Performance reports that identify adherence to performance standards defined by DHSS for each component (i.e., performance monitoring and online dashboard)
WMT31	Create the ability to allow users to produce work management reports to include performance measures online by individual business unit, business process, and compare them to actual performance.
WMT32	Create tickler and/or to-do list capability.
WMT33	Provide an automatic update process as tasks are completed.
WMT34	Provide the ability for a user to set a reminder.
WMT35	Provide the ability for a user to view all their reminders.
WMT36	Provide the ability for a user to reserve a work item for their exclusive use.
WMT37	Provide the ability for a user to view all their reserved work items.
WMT38	Create work items in workflow, as a result of alerts from the web portal when changes occur.
WMT39	Create the ability to allow users to easily add user-defined system and personal alerts, such as ticklers and reminders without requiring technical assistance including: a. The ability to generate alerts that assist in monitoring time-sensitive activities (i.e., completion of reports, interface execution, business process completion such as auto assignment) b. The ability to generate alerts due to changes in policy, system functionality, status, and the generation, distribution, and return of correspondence c. The ability to generate alerts based on the characteristics of providers, members, claims and other entity or case types (i.e., COB, SUR cases)
WMT40	Provide production reports for both open and closed work items by type, and by user, as defined by the DHSS.
WMT41	Create the ability to search by characteristic such as: service type, name of provider, provider number, member name, member number, Service Authorization number, category of service, clerk identification, Contractor EIN, unique workflow ID, assigned user/group and any combinations thereof.
WMT42	Create a single Workflow Management Repository linking all images and correspondence using electronic time and date stamp.
WMT43	The system should have the ability to link together separate workflow records or

Workflow Management – Technical Requirements	
	customer service requests as specified by DHSS.
WMT44	Support workflow mechanisms for all aspects of MMIS functions including but not limited to: a. Eligibility verification b. Member management c. Prior Authorization d. Claims processing e. Suspense resolution f. Appeals and Grievances g. Provider Enrollment h. Provider and customer service management i. Coordination of Benefits j. Customer Relationship management k. Data management l. Utilization management m. Managed Care management n. Financial management o. Administrative reporting p. Performance and auditing reporting q. TPL
WMT45	Create the ability to track and resolve contacts, including calls, onsite visits, override requests, prior approvals, and written inquiries.
WMT46	Create the ability to allow all case tracking activities to be reported to a group of assigned users as well as individual users.
WMT47	Create a process to track the receipt of requests or inquiries via telephone, fax, or email.
WMT48	Create a process to track and image all correspondence, including State memos, between the State and the Contractor.
WMT49	Create a process to track and retain an image of all outgoing correspondence to providers, members, and contractors.
WMT50	Create an Imaging and Workflow Engine to capture, route and track workflow including transaction and documentation images and all other electronic media records.
WMT51	Provide a workflow tracking process, to track and control time-sensitive activities, including, but not limited to: a. Complaints b. Administrative reviews c. Fair hearings
WMT52	Create a method to track the provider application process.
WMT53	Create the ability to accept documents through various input methods, including, but not limited to: Web Portal, Email, Fax, Internal creation from Personal Computers (PCs), Imaging, System generated, and Mailroom.
WMT54	Create a graphical user interface (GUI) to support the development and maintenance of the business processes. Allow users to create a visual capability or flowchart that controls the sequencing of manual and automated tasks performed throughout the business cycle.
WMT55	Create and support a role-based interface for process definition that leads the user through the steps of defining the workflow associated with a business process, including processes that are managed by DHSS staff only; and that captures all the information needed by the workflow engine to execute that process, to include, but not be limited to:

Workflow Management – Technical Requirements	
	a. Start and completion conditions b. Activities and rules for navigation between processes c. Tasks to be undertaken by DHSS staff involved in the process d. Authorized approvers, including electronic signatures e. References to applications which may need to be invoked f. Definition of other workflow-relevant data
WMT56	Create a user-friendly graphical user interface (GUI) for process definition, execution, monitoring, and management.
WMT57	Create the ability to monitor the implementation of business processes in real-time, evaluate the impact of their implementation, and then manage implementation in response to changes in business.
WMT58	Create the ability to update and access status of a process within a workflow (e.g., started, completed, at step 3, waiting for approval).
WMT59	Create the ability to provide convenient, instant access to current and historical information without requiring a separate sign-on beyond the initial MMIS/DSS sign-on.
WMT60	Create an audit trail to record the authorized user who entered the PA, stamp date and time, and provide tools for workflow management to push PA request to those entities required to take action.
WMT61	Create the ability to maintain a historical record of each person who works on a claim or initiates an update to a field within the MMIS.
WMT62	Provide a Workflow Management Module that ensures data security.
WMT63	Create the ability to identify key interfaces to support integration with a variety of best-in-class applications, to support process execution.
WMT64	Allow the process definition to be specified in terms of organizations and roles, with later linkage to specific participants.

C.5.3.4 Rules Engine Business Area

The rules engine may be useful for any process in which technical rules need to be entered, presented, and analyzed by a non-technical Contractor or DHSS staff. Previous programming experience shall not be required to make rule changes.

The Contractor shall employ a COTS, state-of-the-art business rules engine or business process management software to record business rules for many business functions, such as provider enrollment, claims processing, benefit package definition, and prior authorizations.

The Rules Engine shall provide the following capabilities:

C.5.3.4.1 Contractor Technical Requirements

Rules Engine – Technical Requirements	
RET1	Allow for rules to be implemented and maintained in a real-time enterprise environment and applied as directed by the State.
RET2	Provide the functionality to change the rules.
RET3	Provide capability for the user to view rules online and trace exception rule dependencies.
RET4	Provide a rules search capability by keyword, data element or other criteria so that staff may search for existing rules.
RET5	Develop and maintain a procedure identifying all information that resulted in the implementation of business rule.
RET6	Provide a flexible graphical user interface to the Rules Engine.

Rules Engine – Technical Requirements	
RET7	Allow rules to be tested against production data prior to activation.
RET8	Create and maintain a process for built-in rule review and approval that will identify any conflicts in business rules as they are being developed.
RET9	Provide a debugging process that automatically analyzes and identifies logical errors (i.e., conflict, redundancy and incompleteness) across business rules.
RET10	Provide the functionality for the creation of "What-If" analysis using the rules engine.
RET11	Provide a comprehensive rules engine design to support multiple health programs and service delivery and payment methods to include managed care, FFS and waiver arrangements. The design must include the capability to develop and maintain both a business and technical definition of rules related to the following general categories including but not limited to: a. Client rules b. Provider rules c. Benefit plan rules d. Claim adjudication rules (including adjustments) e. Reference rules f. Managed Care rules g. Financial rules h. Federal reporting rules i. Prior Authorization
RET12	Create complex rules that support the automatic creation of transactions (e.g., automatic PA for drug claim with relevant diagnosis).
RET13	Create a module concept so the same Rules Engine can be used by different services or be called as a service itself.
RET14	Provide a rules engine to meet rules growth and processing demands.
RET15	Allow online viewing and printing of a complete or partial list of business rules in human-readable form.
RET16	Provide a business rules engines that is separate from other modules (e.g., client module, provider module).
RET17	Produce documentation regarding the creation, implementation and modification of all business rules.
RET18	Integrate with other components using an enterprise service bus in a SOA environment.
RET19	Provide complete tracking and reporting of rules usage.
RET20	Store all rules maintenance activities in an audit trail that provides a history of the rules changes. Provide capability to ensure that all rules changes are recorded and retained in a long-term audit repository saving the before and after version of the change and the date, time and identification of the individual who made the change and the effective time period of the rule.
RET21	Provide the capability to establish and link notes to rules to explain why the rule was modified, created or inactivated.
RET22	Allow rules to be grouped and prioritized for business needs and efficiency.
RET23	Provide the ability to click on any data element described in the rule and view the detailed metadata about that data element.
RET24	Provide role-based security to the rules.

C.5.3.5 Third Party Liability

The TPL processing function helps the State of Delaware utilize the private health, Medicare, and other third-party resources of its medical assistance clients, and ensures that Medicaid and the State are the payers of last resort. This function works through a combination of cost

avoidance (non-payment of billed amounts for which a third party may be liable) and post-payment recovery (post-payment collection of Medicaid and the State paid amounts for which a third party is liable).

Cost avoidance is the preferred method for processing claim records with TPL. This method is implemented automatically by the MMIS through the application of edits and audits which check claim information against various data fields on client, TPL, provider, reference, or other MMIS tables/files. Post-payment recovery is primarily a backup process to cost avoidance, and is also used in certain situations where cost avoidance is impractical or not allowed.

Casualty is the portion of third-party recovery that allows the State to recover funds on claims paid for clients that are involved in personal injuries, illnesses, or other incidents in which another party may be responsible for payment. These recoveries come from potentially liable third parties and are generally pursued through litigation or filing claims with casualty insurers.

Some objectives for the TPL Business Area are:

1. Process data match and billing
2. Maintain TPL Data
3. Research Suspect Information
4. Cost Avoidance and Pay and Chase Activities
5. Case Tracking
6. Estate Recovery
7. Accident Case Recovery

C.5.3.5.1 Contractor Business Responsibilities

Third Party Liability – Business Responsibilities	
TPLB1	Section 9503 (a) of Consolidated Omnibus Budget Reconciliation Act (COBRA) requires States to submit a plan for pursuing claims against third party resources. The FA will conduct Third Party Liability functionality and processes for the Delaware Medicaid Program and will include these activities: a. Identifying third parties for DMAP clients b. Determining the liability of third parties c. Cost avoiding claims with TPL d. Conducting pay and chase activities for payments made e. Editing for diagnosis and trauma codes f. Tracking and reporting all TPL activities and results to the State
TPLB2	Maintain a report of all clients who qualify to be added or deleted with Part A or Part B buy-in coverage. These clients that can potentially be accreted/deleted will be researched by FA buy-in clerk for possible action.
TPLB3	Maintain and balance deposited recoveries against processed dispositions and report the break-out of TPL by funding source.
TPLB4	Operate the TPL processing function of the DMES.
TPLB5	Maintain and support online update and inquiry access to; TPL carrier information, employer health plan information, TPL case tracking information, and TPL accounts receivable for State staff.
TPLB6	Provide ongoing training support to State personnel in the use of existing or new TPL system functionality and schedule as determined by the State.

Third Party Liability – Business Responsibilities	
TPLB7	Maintain all TPL supporting system documentation, and update documentation within 15 business days of any changes.
TPLB8	Maintain and update TPL user's manual annually or when directed by the State.
TPLB9	Maintain and update TPL procedure manuals annually or when directed by the State.
TPLB10	Provide updates to the user and operations manuals to the State annually. The State will determine in which form(s) of media the Contractor must deliver the documents.
TPLB11	Notify State when updates are made to all manuals, and identify what changes have been made.
TPLB12	Deliver all reports created by the TPL function according to State specifications.
TPLB13	Produce online and paper claim facsimiles, microform claim copies, and/or billing forms to invoice third parties for claim records requiring post payment recovery, and mail them out with an appropriate cover letter.
TPLB14	Maintain data exchange system with insurance carriers and governmental agencies, and perform the data exchange process.
TPLB15	Collect and provide to the State initial and ongoing third party resource information from all available sources for all clients.
TPLB16	Provide monthly full files of carrier and employer data to the State and the TPL Contractor, and other time periods as directed by the State.
TPLB17	Maintain electronic claim records to assist the State in TPL investigations.
TPLB18	Make recommendations for improvements to TPL processing.
TPLB19	Support all TPL functions, files, and data elements necessary to meet the requirements of this RFP, CMS certification standards, and the State Medicaid Manual.
TPLB20	Provide support to pharmacy TPL issues.
TPLB21	Report new and changed TPL information to the TPL Unit within 1 business day of discovery.
TPLB22	Initiate post payment recovery within 30 days of discovery of a TPL resource.
TPLB23	Generate and mail second and third requests no later than 60 and 90 days after first request if no response is received and notify State if no response is received after 90 days at the bimonthly TPL meeting.
TPLB24	Conduct bimonthly TPL meetings with the State to discuss pay & chase, disallowance, current projects, outstanding TPL accounts, or other topics directed by the State.
TPLB25	Receive and process checks from the State daily; and maintain and update the accounts receivable system on a daily basis.
TPLB26	Review and initiate follow-up action on aged accounts receivable according to State instruction.
TPLB27	Checks for receivables and EOBs for both payments and denials are submitted by carriers to FA lockbox and further processed by the TPL Contractor.
TPLB28	Process the Medicare Enrollment Database (EDB) file against the DMES eligibility file to identify clients with Medicare Part A and/or B and process recoupment transactions accordingly.
TPLB29	Weekly inform DHSS by email advising the Medicare disallowance recoupments for the prior week.
TPLB30	Correspond on a weekly basis via email and telephone to review operational tasks. At least biweekly participate in conference call with State staff to review ongoing collections process and operational tasks.
TPLB31	Send the State a wire transfer followed by an email with the amount of the transfer to the TPL unit. Monthly invoice is sent by the FA to the State with amount itemized into pay & chase collected and the disallowance collected.

Third Party Liability – Business Responsibilities	
TPLB32	Retain one FTE TPL Analyst.
TPLB33	Annually update Part D Premium rates.
TPLB34	The FA performs monthly reconciliations with the Part D carriers.
TPLB35	PDP landscape annually for all new and existing plans, and all premiums for the different subsidy levels.
TPLB36	Cull out from CMS published plans State specific plans, send information to the State, and update the system.
TPLB37	Provide Part D support for all clients as directed by the State, to include but not to be limited to both DPAP clients and CRDP clients.
TPLB38	Process dual eligible client enrollment reports.

C.5.3.5.2 Contractor Technical Requirements

Third Party Liability – Technical Requirements	
TPLT1	Provides the storage and retrieval of TPL information including: a. Enrollment suspended b. Name of insurance company c. Address of insurance company d. Policy number e. Group number f. Name of policyholder g. Relationship to Medicaid Client h. Services covered i. Policy period j. Multiple resources under one Client k. Group health plan participants
TPLT2	Provide the capability to perform the following TPL functions and update the MMIS accordingly: a. Data matches with files from other government programs, private insurance companies, or other State specified sources b. Health coverage data, including retroactive changes to TPL data, supplied by the State via DCIS II and other sources c. TPL-related data from claim records, claim attachments, or claims history files, including but not limited to: 1. Diagnosis codes, procedure codes, or other indicators suggesting trauma, accident or such as long-term care for estate recovery 2. Indication that a TPL payment has been made for the claim (including Medicare) 3. Indication that the client has reported the existence of TPL to the provider submitting the claim 4. Indication that TPL is not available for the service claimed 5. Subrogation indicators d. Client eligibility and TPL resource information from the State based on initial and continuing client eligibility determinations e. TPL information developed by claim records resolution workers following TPL edit errors f. TPL data exchanges with Medicaid MCOs, or other contracted entities during the regular electronic transmission of client eligibility data g. Correspondence and phone calls from clients, insurance companies, and providers

Third Party Liability – Technical Requirements	
	h. Parameters entered online to identify paid claim records for tracking and potential recovery including Recorder of Deeds information i. Client, reference, and provider data
TPLT3	Provide the ability to maintain accurate third party resource information by client including but not limited to: a. Client name, identification number, date of birth, date of death, and SSN b. Name and address of policyholder c. Policyholder relationship to client d. Policy and/or group number including Medicare HIC number; e. Employer name and address f. Type of policy (accident, MCO, Medicare supplemental) g. Coverage codes h. Covered claim types i. Coverage begin date j. Coverage end date k. Coverage limitations l. Assignment/subrogation m. Coinsurance/copayment information n. Annual deductible amount o. Indicator of TPL resource exhaustion p. HIPP indicator q. Premium amount r. Annual limits s. Date and source of TPL resource verification t. Insurance company name and ID
TPLT4	Provide for multiple TPL resources (including Medicare) per client, and maintain an unlimited number of date-specific TPL resources for each client.
TPLT5	Maintain current and historical information on third party resources for each client for a period of time to be determined by the State.
TPLT6	Maintain a user defined table driven TPL matrix for cost avoidance editing.
TPLT7	Maintain employer data information and the associated health care plans offered to employees, that includes but is not limited to: a. Employer name and identification data (SSN/FEIN, State Tax ID) b. Employer address and telephone numbers c. Employer group number d. Identification of all health plans offered (a minimum of 20 occurrences) e. Insurance company ID, name, address, telephone number) f. Insurance company type (managed care, health, etc.) g. Identification of the plan certification and termination dates applicable to the employer h. Identification of primary or secondary plans i. Type(s) of health plans (group plan, large group health plan, and the like)
TPLT8	Maintain the ability to retrieve paid claim records from history based on parameters including but not limited to: a. Pay date b. Date of service c. Claim type d. Provider NPI and taxonomy e. Provider type f. Provider specialty

Third Party Liability – Technical Requirements	
	g. Revenue center code h. Category of service i. Client ID j. Client geographic/demographic location k. Eligibility category, including Qualified Medicare Client (QMB) or Specified Low Income Medicare Client (SLMB) or Qualified Disabled Working Individual (QDWI) l. Diagnosis Related Group (DRG) code m. Diagnosis code or range n. Procedure code o. RA number p. Drug code q. Drug therapeutic class
TPLT9	Generate listings and totals of cost avoided claims.
TPLT10	Provide the ability to generate detail and summary reports of third party payments made.
TPLT11	Generate listings and totals of potential recovery claims based on user input selection parameters.
TPLT12	Provide the ability to track and report amounts billed and collected on current and historical cases, by insurance company and by client.
TPLT13	Generate an aging report for attempted recoveries by insurance company and by client to include details of type and reason for recovery, and monetary value.
TPLT14	Report the number and amount of recoveries by type; for example, estate recovery, accident and trauma, or private insurance, and additional categories as directed by the State.
TPLT15	Report potential trauma and/or accident claim records that meet a specified dollar threshold as determined by the State.
TPLT16	Provide unduplicated cost avoidance reporting by program category and by type of service, with accurate totals and subtotals, as directed by the State.
TPLT17	Provide monthly listings of TPL carrier data.
TPLT18	Provide the capability to maintain audit trails of changes to TPL data and create reports as directed by the State.
TPLT19	Create detail and summary reports of premiums paid, client deductibles, and coinsurance paid by Medicaid on behalf of the client.
TPLT20	Provide the capability to generate letters for the TPL business area as directed by the State.
TPLT21	Provide the capability for claim summary information to be sent electronically or on paper to attorneys, insurance companies and other parties as directed by the State.
TPLT22	Provide online viewing of TPL information to include data elements as directed by the State.
TPLT23	Create reports of client TPL resources terminated during a specified reporting period.
TPLT24	Generate federally required reports on cost avoidance and collections as directed by the State.
TPLT25	Provide for online real-time updates to client, company, and health insurance data and the TPL Cost Avoidance Matrix and tables.
TPLT26	Provide for batch updates to client, company, health insurance data, estates, and the TPL Cost Avoidance Matrix and tables.
TPLT27	Provide the ability to make mass changes on any TPL field and change the coverage for multiple TPL fields for multiple clients.
TPLT28	Provide the ability for cost avoidance on multiple TPL policies for a single Medicaid client.

Third Party Liability – Technical Requirements	
TPLT29	Provide the capability of producing a claim in hardcopy and electronic format.
TPLT30	Enable the type of TPL recovery to be identified in the Financial module.
TPLT31	Enable the type of TPL recovery to be identified in the Claims History File.
TPLT32	Provide capability to reconcile data between internal modules (e.g., TPL, Pharmacy, Eligibility, etc.) on a predetermined schedule and keep all data in sync.
TPLT33	Provide the ability for all TPL recoveries to be identified by case type.
TPLT34	Provide the capability to verify coverage codes that have been added, changed, or discontinued from TPL coverage.
TPLT35	Provide online notes capability for narrative about each TPL information data field.
TPLT36	Maintain a process for premium payments and create monthly reports of payment made.
TPLT37	For Medicare Buy-In generate automatic accretion, discontinuation, and/or re-accretion requests, subject to the approval of the State.
TPLT38	Provides the storage and retrieval of casualty-related information (e.g., motor vehicle accident and workers' compensation information).
TPLT39	Identifies and follows up on third party information from all sources.
TPLT40	Identifies claims with trauma diagnosis codes, accident codes and indicators and routes them for follow-up to see if there is TPL.
TPLT41	Produces letters and tracks original and follow-up letters to employers, insurers, Clients and others to verify health coverage.
TPLT42	Automatically generates casualty-related follow-up to Clients, attorneys, motor vehicle department, etc. according to State-specified criteria.
TPLT43	Accepts and processes verification data from employers, insurance companies, providers, Clients, attorneys and others. Verification data should include the type of insurance coverage for each policy (e.g., inpatient, outpatient, physician, pharmacy, and dental).
TPLT44	Maintains all third party resource information at the Client–specific level.
TPLT45	Provide the capability to identify third party resources that are liable for some, or all, of the client's medical claim by client, including absent parent.
TPLT46	Maintains multiple third party coverage information for individual Clients for all of their periods of eligibility.
TPLT47	Accept and apply updates to multiple TPL resource information for each client and historical resource data for each client that are date and benefit coverage specific.
TPLT48	Identifies the source of TPL information (e.g., X12N 270 eligibility determination, insurance company).
TPLT49	Support the use of the X12N 270/271 transaction between entities.
TPLT50	Edits TPL data updates for validity and for consistency with existing TPL data.
TPLT51	Edits additions and updates to the Client insurance information to prevent the addition of duplicates.
TPLT52	Provides a mechanism to correct outdated TPL information.
TPLT53	Generates and maintains an audit trail of all updates to the Client insurance data, including those updates that were not applied due to errors, for a time period specified by the State.
TPLT54	Maintain electronic file with audit history of file updates.
TPLT55	Cross-references the health insurance carriers to the employers.
TPLT56	Allows only authorized staff members to do manual deletes and overrides of alerts/edits.
TPLT57	Identifies claims designated as "mandatory pay and chase", makes 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

Third Party Liability – Technical Requirements	
	identify prenatal care services provided to pregnant women and preventive pediatric services provided to children).
TPLT58	Create a process that will evaluate a client's TPL information and close a client's eligibility when TPL has been identified retroactively. Create and send client notice to communicate closure of their eligibility.
TPLT59	Create report to balance deposited recoveries against processed MMIS dispositions and break-out cost recoveries by funding source.
TPLT60	Screens claims to determine if claims are for Clients 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.
TPLT61	Maintain a process to identify previously paid claim records for recovery when TPL resources are identified or verified retroactively, and to initiate recovery within a time period specified by the State.
TPLT62	Provide the ability to create, modify or close existing cases.
TPLT63	Maintain process for selecting claim records for post payment recovery cases.
TPLT64	Implement processing procedures which identify and support recovery actions on Medicaid paid claim records which become eligible for Medicare coverage as the result of a successful Medicare appeal process.
TPLT65	Generate automatically the initial, and all follow-up, notices for payment requests to the third party for all claims (medical, institutional and/or pharmacy) that were covered by that TPL carrier.
TPLT66	Marks the claim for "pay and chase," as provided by State rules.
TPLT67	Accounts for TPL payments to providers in determining the appropriate Medicaid payment.
TPLT68	Tracks and reports cost avoidance dollars.
TPLT69	Perform TPL editing using the TPL cost avoidance matrix, client policy data, and timely filing data.
TPLT70	Identify all payment costs avoided due to established TPL, as defined by the State and federal governments.
TPLT71	Provide for automated tracking of recoveries by funding source, and posting of recoveries to individual claim histories.
TPLT72	Provide the capability to create a recovery case that includes both summary and detail criteria as directed by the State.
TPLT73	Provide for unique identification of recovery records.
TPLT74	Maintain and display online all claim details associated with a case as directed by the State.
TPLT75	Accept free-form user notes on all recovery records.
TPLT76	Provide a process to perform data matching with other government agencies and private insurers to identify potential TPL resources.
TPLT77	Allows for payment of claims that would have been rejected due to TPL coverage if provider includes override codes that indicates that benefits are not available.
TPLT78	Generate a report on all overrides done by the provider.
TPLT79	Supports recovery from an estate or designated trust.
TPLT80	Produce a Monthly TPL Recovery Report by case type.
TPLT81	Screens verified TPL resources against paid claims history retroactively for 3 years to identify recoverable funds.
TPLT82	Maintain an automated process for billing liable third parties and track all recoveries.

Third Party Liability – Technical Requirements	
TPLT83	Accumulates claims up to a specified threshold amount and seeks TPL recovery when the threshold is reached.
TPLT84	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.
TPLT85	Accept, process, and respond to the HIPAA standard X12N 837 TPL segment on a claim transaction.
TPLT86	Generate X12N 837 or an electronic payer subrogation claim transaction for billing Medicare or other insurance carriers when a determination is made that the client was eligible for coverage under another plan, including Medicare, when the claims were paid.
TPLT87	Automatically re-bills insurance companies if a response (payment or denial) is not received within State-specified guidelines.
TPLT88	Be able to regenerate claims, as needed, when claims are sent to the wrong carrier billing address.
TPLT89	Associates third party recoveries to individual claims.
TPLT90	Manages accounts receivable and claims adjustments as TPL related invoices are paid.
TPLT91	Automate claim specific adjustments for retroactive recoveries.
TPLT92	Designates portions of claim amounts collected to reimburse CMS and the State with any remainder paid to the client.
TPLT93	Provide for the storage and retrieval of Medicare information for the proper administration of Medicare crossover claims and ensure maximum cost avoidance when Medicare is available.
TPLT94	Transmit the appropriate information to Medicare for the efficient and effective administration of Medicare Part D.
TPLT95	Identifies Clients for referral to the Lock-in program.
TPLT96	Provide the ability to override TPL pharmacy editing to allow POS processing for product, co-pay, and other reasons.
TPLT97	TPL accounts receivable for recoveries must be integrated within the consolidated accounts receivable and payable systems.
TPLT98	Provide processes and data to meet, at a minimum, requirements of the State Medicaid Manual, Part 11 and Section 3900, State Medicaid Manual, Part 3.
TPLT99	Provide the ability to disallow Medicare and commercial insurance claims as directed by the State.

C.5.3.6 Program Management

The Program Management business area supports strategic planning, policy making, monitoring, and oversight activities of the DHSS. Program Management functions are involved in the support of decision-making activities including; benefit plan design, rate setting, healthcare outcome targets, and cost-management decisions, budget analysis, accounting, quality assessment, performance analysis, outcome analysis, continuity of operations plan, and information management.

The Program Management function ensures that data reported to all State and federal agencies is timely and accurate and that there are appropriate financial modeling tools to monitor program utilization and trends. There are two sub-functions associated with the Program Management area that help manage program management-related responsibilities:

- Program Management Reporting

- Federal Reporting

C.5.3.6.1 Program Management Reporting

The Program Management Reporting area is responsible for implementing appropriate financial modeling, analyzing Medicaid Program costs, monitoring payment processes, and predicting trends and impact of policy changes on programs. This area also maintains and supports and efficient and effective management reporting process.

Objectives for Program Management Reporting are:

1. Analyze Medicaid program costs and trends to predict impact of policy changes on programs
2. Monitor payment processes and predict trends
3. Analyze provider performance to show extent of participation and service delivery
4. Analyze Beneficiary enrollment, participation, and program usage to predict utilization trends, and
5. Maintain an efficient and effective management reporting process

C.5.3.6.1.1 Contractor Technical Requirements

Program Management – Technical Requirements	
PMT1	Provides information to assist management in fiscal planning and control.
PMT2	Provide quarterly reports that compute savings for each therapeutic drug class that are derived from supplemental rebate agreements and/or from the PDL via shifts in market share (net of federal rebate and EQROA).
PMT3	Provide the capability for the Medicaid Enterprise to generate data for production reports based on specifications provided by the DHSS.
PMT4	Provides information required in the review and development of medical assistance policy and regulations.
PMT5	Provides information necessary to conduct a fiscal impact analysis as part of the review and development of medical assistance policy and regulations.
PMT6	Prepares information to support the preparation of budget allocations for the fiscal year.
PMT7	Provide analysis tools and reports that can provide utilization trend analysis by type of service.
PMT8	Supports the projection of the cost of program services for future periods.
PMT9	Compares current costs with previous period cost to establish a frame of reference for analyzing current cash flow.
PMT10	Compares current payments with previous period payments to establish a frame of reference for analyzing current cash flow.
PMT11	Compares actual expenditures with budget to determine and support control of current and projected financial position.
PMT12	Enables comparison of actual expenditures with budget to determine and support control of current and projected financial position and to explain variance.
PMT13	Provide analysis tools and reports that have the functionality to compare encounter claims between MCOs for the same or like services provided, and to report on the services over flexible time spans.
PMT14	Analyzes various areas of expenditure to determine areas of greatest cost.
PMT15	Analyze areas of program expenditure to determine relative cost benefit.
PMT16	Provides data necessary to set and monitor rate-based reimbursement (e.g., institutional per diems and Managed Care Organization (MCO) capitation).
PMT17	Maintains provider, recipient, claims processing, and other data to support agency

Program Management – Technical Requirements	
	management reports and analyses.
PMT18	Provides counts of services based on meaningful units such as but not limited to: a. Service category (e.g., days, visits, hours, drug quantity) b. Unduplicated claims c. Unduplicated clients d. Unduplicated providers
PMT19	Provides counts for services for various periods (financial cycle, month, qtr, fiscal year) such as but not limited to: a. Paid Units by service category (e.g., days, visits, hours, drug quantity) b. Providers by service category c. Unduplicated claims d. Unduplicated clients e. Unduplicated providers
PMT20	Identify drug payments and drug utilization by given parameters, not limited to the following: a. Specific national drug codes b. Specific therapeutic classes, generic cross reference numbers, plans, Providers and Recipients c. Specific population coverage groups, gender, age, payment methodology, etc. for cost and trend analysis and budget planning d. Impact of Medicare drug program
PMT21	Supports online real time summary information such as, but not limited to, number and type of providers, clients and services.
PMT22	Tracks claims processing financial activities and provides reports on current status of payments and whether federal payment timeliness standards are being met.
PMT23	Provides the capability to produce unduplicated counts of clients and paid units within a category of service and in total by specified periods of time.
PMT24	Reports the utilization and cost of services against benefit limitations.
PMT25	Provides the capability to analyze the impact of proposed implementation of benefit limits.
PMT26	Assists in determining reimbursement methodologies by providing expenditure data through service codes including: a. Healthcare Common Procedure Coding System (HCPCS), current version b. International Classification of Diseases and Related Health Problems, Clinical Modification (ICD-CM), current version c. National Drug Code (NDC), current version
PMT27	Provide expenditure data at the procedure code level (for HIPAA standard coding systems) as specified by the State.
PMT28	Produces an annual hospice report showing a comparison of hospice days versus inpatient days for each enrolled hospice Client and for all hospice providers.
PMT29	Produces an annual hospice report for the period November 1 – October 31 that compares aggregate hospice days to inpatient days for all hospice providers in order to compute the “hospice cap.”
PMT30	Analyzes break-even point between Medicare and Medicaid payments to enable the state to determine whether it is cost effective to pay the Medicare Part A and B premiums for dual eligibles to enable Medicare to be the primary payer.
PMT31	Supports DHSS’ ability to produce budget neutrality reports for the 1115 and HCBS waivers by comparing with-waiver expenditures to without-waiver costs (as specified or approved by CMS).
PMT32	Analyzes cost effectiveness of managed care programs versus fee-for-service.
PMT33	Must have the capability of reporting on changes from a specified baseline for program or policy changes as specified by the State.
PMT34	Reports on errors in claim and payment processing by provider to determine potential areas for improvement and areas where provider billing training could reduce billing errors.

Program Management – Technical Requirements	
PMT35	Provides claims processing and payment information by provider/service type to analyze timely processing of provider claims according to requirements (standards) contained at 42 CFR 447.45
PMT36	Provide analysis tools and reports that have the functionality to compare aggregate charges and allowable payments for same or like services, over flexible time spans, statewide, or by geographical areas.
PMT37	Monitors third party liability cost avoidance, pay and chase collections, and provider recoupments per State plan to ensure that Title XIX is the payer of last resort.
PMT38	Retains all information necessary to support State and federal program initiatives and reporting requirements.
PMT39	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.
PMT40	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.
PMT41	Identifies payments by reporting categories (i.e., abortions and sterilizations) as specified by the State.
PMT42	Develops third party payment profiles to determine where program cost reductions might be achieved.
PMT43	Maintains information on per diem rates, Diagnosis Related Groups (DRG), Resource Utilization Groups (RUG) % of charges or other index and other payment methodologies as specified by the State.
PMT44	Automatically alerts administration when significant change or event occurs in daily, weekly, or other time period processing, as specified by the State.
PMT45	Reviews provider enrollment and quantifies participation to determine the adequacy of client access to health care.
PMT46	Provide the capability to compare individual provider participation to other providers of the same type and specialty.
PMT47	Reviews provider participation and analyzes provider service capacity in terms of Client access to health care.
PMT48	Analyze provider claim filing for timeliness, fiscal controls and ranking.
PMT49	Provides online access to information for each provider on payments to monitor trends in accounts payable, including but not limited to, showing increases/decreases and cumulative year to date figures after each claims processing cycle.
PMT50	Produces information on liens and levies and providers with credit balances.
PMT51	Enables online view of provider participation data and summaries by different select criteria including but not limited to: a. Payments b. Category of Service c. Administration Sanctions d. Client eligibility categories
PMT52	Provides information to assist auditors in reviewing provider costs and establishing a basis for cost settlements.
PMT53	Monitors individual provider payments.
PMT54	Provide the capability to perform data analysis functions, statewide or by geographical area, for services provided to clients through the Delaware Medicaid Program, including utilization by client.
PMT55	Provide the ability to monitor the health status of clients and impact on cost.
PMT56	Analyzes progress in accreting eligible Medicare buy-in Clients.
PMT57	Supports analyses of data on individual drug usage.
PMT58	Support trend analysis and exception reporting capabilities of drug use by individual and by eligibility category for cost, potential client or prescriber abuse, improperly utilized drugs or procedures, with an emphasis on the impact of improper utilization to health outcome.
PMT59	Provide trend analysis and exception reporting capabilities to identify improperly utilized

Program Management – Technical Requirements	
	drugs or procedures, with an emphasis on the impact of improper utilization to health outcome.
PMT60	Presents geographic analysis of expenditures and Client participation.
PMT61	Provides Client data (including Long Term Care (LTC), Early Periodic Screening, Diagnosis and Treatment (EPSDT), and insurance information) for designated time periods.
PMT62	Summarizes expenditures, based on federal and state-specific expenditure categories including both service and client eligibility groupings for each federal program (XIX and XXI).
PMT63	Summarizes expenditures based on state specific expenditure categories including both service and client eligibility groupings for each State program.
PMT64	Provides eligibility and Client enrollment counts and trends by selected data elements such as, but not limited to, aid category, type of service, age, and county.
PMT65	Provides Client enrollment and participation analysis and summary, showing utilization rates, payments and number of clients by eligibility category.
PMT66	Provide for client counts by program to support cost allocation processes.
PMT67	Provide for claim counts by program to support cost allocation processes.
PMT68	Provides the ability to request information online and to properly categorize services based on benefit plan structure.
PMT69	Reports on dual eligibles pre and post Medicare Part D implementation.
PMT70	Support the process of determining which clients are subject to the phased down State contribution payment related to Medicare Part D by identifying the numbers and types of Medicaid and Medicare dual eligibles and submitting a monthly enrollment file, identifying each full-benefit dual eligible individual enrolled in the State for each month. This file must include specified information including identifying information, a dual eligible type code, available income data and institutional status. The file includes data on enrollment for the current month, plus retroactive changes in enrollment characteristics for prior months.
PMT71	Supports report balancing and verification procedures.
PMT72	Provide the ability to aggregate payments for high cost clients, as defined by the State.
PMT73	Maintains comprehensive list of standard PM reports, their intended use (business area supported), any limitations to our caveats regarding their use and a list of report users.
PMT74	Provide users easy and quick access to production reports from their workstations, including, but not limited to: a. Query all MMIS databases b. Build and run queries from their desktops c. Traverse and drill down the data d. View all MMIS reports online e. Export data and reports to desktop packages, such as Excel, Word, ACCESS, text files, and other software packages available on the State LAN/WAN f. Develop and save queries for future use g. View online documentation, including dictionary of data and data fields for each report
PMT75	Maintains online access to at least 4 years of selected management reports and 5 years of annual reports.
PMT76	Provide the capability to archive all MMIS management reports for permanent storage in electronic media approved by the DHSS.
PMT77	Provide for online viewing of all production reports with the capability to sort, filter, export, and print the report or selected portions of the report from the user's desktop. Online reports will be available on request by the DHSS, in the media specified by the user (e.g., downloadable file, optical storage, or hard copy).
PMT78	Provide the ability to run any report at any time.
PMT79	Retain annual reports, per DHSS requirements.

Program Management – Technical Requirements	
PMT80	Meets State defined time frames and priorities for processing user requests.

C.5.3.6.2 Federal Reporting

The Federal Reporting functional area is responsible for creating and, in some cases, submitting federally required reports (e.g., MSIS, EPSDT, CMS 64) related to the DMES. The Contractor must produce the required management data for these reports in a format specified by the State. This area also supports incorporating managed care encounter data into MSIS reports.

The FA has the responsibility of confirming that the Federal Reporting monthly summary process results are reconciled and balanced; resolving any problems associated with the outcome. The FA completes a monthly balancing report to ensure that Federal Reporting summarization process numbers match those generated from the weekly claim, financial, payout and recoupment transactions, and are compared with funding source and balanced.

Objectives for the Federal Reporting Business Area are:

1. Receive Extracts and Update MAR Database
2. Produce Summary Reports
3. Produce Expenditure Summary Reports
4. Produce CMS Reports
5. Produce LTC Summary Reports
6. Produce Provider Summary Reports
7. Produce Client Summary Reports
8. Produce Drug Summary Reports
9. Produce Claim Processing Summary Reports

C.5.3.6.2.1 Contractor Business Responsibilities

Federal Reporting – Business Responsibilities	
FRB1	Operate and maintain the Management and Administrative Reporting function of the DMES according to current and future federal Medicaid Enterprise certification requirements, Part 11 of the State Medicaid Manual, and all State requirements.
FRB2	Produce all MAR reports and other outputs within the time frames and according to the format, input parameters, content, frequency, media, and number of copies specified by the State.
FRB3	Generate State-specified reports to be sent to CMS in the federally required format.
FRB4	Generate and deliver State reports for online access.
FRB5	Modify the reports to meet the changing information needs of the Delaware Medical Assistance Program and ensure compliance with changes in federal, State, or DHSS regulation, procedures, or policies.
FRB6	Ensure changes made to funding sources, category of service, and so forth carry through to MAR reports.
FRB7	Maintain complete up-to-date documentation for MAR.
FRB8	Make all MAR reports available online.

Federal Reporting – Business Responsibilities	
FRB9	Balance MARS report data to comparable data from other MARS reports to ensure internal validity, and to non-MARS reports to ensure external validity, and provide an audit trail; deliver the balancing report to the State with each MARS production run.
FRB10	Respond to State requests for information concerning the reports within 3 business days.
FRB11	Provide to State personnel initial and ongoing training in the use of the MAR function, annually, for new hires, and at times and intervals specified by the State.
FRB12	Provide technical assistance as needed to assist users in researching problems, reviewing production outputs, and understanding report formats.
FRB13	Ensure the accuracy of all reports before delivery to the State.
FRB14	Make recommendations on any area in which the Contractor thinks improvements can be made.
FRB15	Support all reporting functions, files, and data elements necessary to meet the requirements in this RFP.
FRB16	Produce, validate, submit, and correct as necessary Medicaid Statistical Information System (MSIS) data according to CMS specifications and maintain internal reports summarizing eligible counts, claim counts, and dollars reported on MSIS files. Maintain related databases for validation purposes.
FRB17	When report deficiencies are identified and substantiated, correct the problem and rerun the report within 5 business days of the State's request.
FRB18	Work with managed care organizations to capture encounter data and work with DHSS to define and implement the State's reporting needs in the DMES.
FRB19	Maintain and support the production of reports on abortions, family planning, and sterilizations.

C.5.3.6.2.2 Contractor Technical Requirements

Federal Reporting – Technical Requirements	
FRT1	Maintains Medicaid and CHIP data sets for MSIS reporting as required.
FRT2	Merges into MSIS data from outside sources if required.
FRT3	Provides and maintains MSIS eligibility and adjudicated claims data in the following files: a. Eligible file b. Inpatient hospital claims c. Long term institutional care claims d. Prescription drugs e. Other claims, not included in the above categories
FRT4	Provides and maintains encounter data in appropriate claim(s) file.
FRT5	Follows the eligibility and claims reporting guidelines from the current *MSIS Tape Specifications and Data Dictionary* document.
FRT6	Meets MSIS reporting timelines, providing MSIS tapes for submission in accordance with the tape delivery schedules.
FRT7	Submits MSIS data according to CMS-approved formats, media, and security procedures. Meets CMS quality assurance edit checks and error tolerance limits.
FRT8	Provides supporting documents within DHSS prescribed formats and time frames, including: a. Copy of MSIS eligibility and claims records for DHSS review and filing b. Summary report with eligibility counts, claims costs/record counts and other statistics
FRT9	Maintains eligibility and service crosswalks that align State-specific categories into eligibility and service/program type codes per MSIS specifications. Maintains Waiver ID

Federal Reporting – Technical Requirements	
	crosswalks and other documentation required by CMS.
FRT10	Provides data validation and quality checks, including ensuring inclusion and correct processing of claim voids and adjustments. Provides on-demand data as follow-up to address CMS concerns, and resubmissions to correct data quality problems in MSIS data.
FRT11	Produces the CMS-416 report in accordance with CMS requirements. The report must include: a. The number of children provided child health screening services b. The number of children referred for corrective treatment c. The number of children receiving dental services d. The State's results in attaining goals set for the State under Section 1905(r) of the Act provided according to a State's screening periodicity schedule
FRT12	Produces the CMS-372 and CMS-372S Annual reports on Home and Community Based Services (HCBS) Waiver Reports, for any HCBS Waivers that exist in accordance with CMS requirements.
FRT13	Provides data to support the production of CMS-64 and CMS-21 expenditures reports and the CMS-21B and CMS-37 program budget reports.
FRT14	Reports drug rebate collections on the CMS-64 and CMS-21, as applicable.
FRT15	Maintains supporting financial reports and other documentation related to CMS 64 and 21 reports that link to and validate figures on these reports. Report formats and schedules will be specified by DHSS.
FRT16	Supports reporting of prior period adjustments for CMS 64 and 21 reports, including identification of original dates of payment.
FRT17	Maintains CMS-64/CMS-21 Category of Service crosswalks that translate State service and/or eligibility categories into CMS-64/CMS-21 service categories, as defined by DHSS.
FRT18	Produce CMS-64 and CMS-21 variance reports, as specified by DHSS that compare the current quarter with the prior quarter and other specified periods. Produces CMS-37 and CMS-21B variance reports that compare the current year with the prior year and other specified periods. The variance reports must be made available within time frames and formats required by the DHSS. Supports on-demand generation of information to address CMS or DHSS questions about variances and other issues.
FRT19	Produces CMS-64 Medical Assistance Expenditure reports within time frames and formats required by DHSS. Reports should mirror CMS-64 forms (entire forms or sections) so that they are ready for submission to MBES system. Report process should consolidate financial data from different MMIS systems (TPL, Buy-in, Drug Rebate, claims processing, collections etc), reflect waiver and non-waiver programs, and reflect different federal matching rates. Report process should ensure completion of relevant CMS-64 report schedules including but not limited to: a. CMS-64.9 Base – Current Quarter expenditures by type of service b. CMS-64.9 Waiver – Section 1115 waiver costs by eligible group and demo year c. CMS-64.9 Waiver – For HCBS Waivers d. CMS-64.21 U – Medicaid Expansion CHIP Health Expenditures by Service e. CMS-64.9 A – Third Party Liability Collections and Cost Avoidance f. CMS-64.9C1 – Fraud, Waste, and Abuse Collections g. CMS-64.9 O – Medicaid Overpayment Adjustment reports (including PERM activity and Fraud, Waste, and Abuse)
FRT20	Provides data on administrative costs, paid by MMIS, for CMS-64.10 State and Local Administration Expenditure reports. Data should be provided within time frames and formats specified by DHSS.
FRT21	Incorporates TPL information on collections and cost avoidance on the CMS-64.
FRT22	Produces CMS-21 reports on Children's Health Insurance Expenditures under Title XXI,

Federal Reporting – Technical Requirements	
	within time frames and formats required by DHSS. Reports should mirror CMS-21 forms (entire forms or sections) so that they are ready for loading into CBES system. Report process should consolidate financial data from different MMIS systems (CHIP premium collection, Drug Rebate, claims processing. collections) and adjust for different federal matching rates. Use data to complete CMS-21 report forms including but not limited to: a. CMS-21 Base-Expenditures In Current Quarter By Type of Services b. Other CMS 21 reports
FRT23	Provides data on administrative costs, paid by MMIS, for inclusion in CMS-21 Reports, within time frames and formats required by DHSS
FRT24	Develops reports on actual expenditures and eligibility counts for inclusion in CMS-37 Medicaid Program Budget reports, within time frames and formats specified by DHSS.
FRT25	Provides ability to generate information on demand to facilitate CMS-37 and CMS-21B budget projections.
FRT26	Produces the Medicaid and CHIP child enrollment reports, for entry in SEDS, according to DHSS and CMS requirements, including: a. CMS-21E CHIP enrollment b. CMS-64.21 E Medicaid Expansion CHIP enrollment report c. CMS-64 EC Medicaid Child Enrollment Report d. Data elements include: 1. Enrollment counts broken down by age groups 2. Income bracket 3. Managed Care arrangement
FRT27	Provides a full audit trail, as defined by the DHSS, to support all transactions used to generate any and all federal reports.
FRT28	Identifies Funding Source classification to ensure that claims and financial transactions are correctly assigned to federal programs (Medicaid, CHIP, and MFP) and any subprograms within these that require separate federal reporting (Diamond State Health Plan, DSHP Plus, Breast and Cervical Cancer, HCBS waiver and other programs).
FRT29	Provides ability to track and report Section 1115 waiver costs by MEG (Medicaid Eligibility Groups) and demonstration year.
FRT30	Provides Budget Neutrality reporting for 1115 waiver that provides for comparison of expenditures with waiver caps, within time frames and formats required by DHSS. Reports should include: a. Member Months b. Expenditures c. Drug Rebate and Collections d. Other statistics specified by DHSS
FRT31	Produce Drug Utilization Review reports that show federal savings by category.
FRT32	Identifies all Family Planning and sterilization expenditures (claims and financial transactions) that qualify for the 90% federal match. Maintains supporting reports, as defined by DHSS that show individual FP and sterilization claims with procedures, diagnosis, and other details.
FRT33	Tracks costs for any services to Medicaid clients that do not qualify for federal match, including IMD clients ages 21 to 64 in Diamond State Partners and HCBS waiver costs funded with Money Follows the Person grant. Provides related reports within time frames and formats required by DHSS.
FRT34	Provides ability to compute federal share of expenditures for DHSS programs by maintaining and applying Federal Financial Participation rate schedules based on program, service category, and payment periods.
FRT35	Create a process to include all claims in the page for the federal invoice type in the

Federal Reporting – Technical Requirements	
	Quarterly Account Receivable Summary Report and Quarterly Supplemental Rebate Account Receivable Summary Report at the funding source level and aggregates.
FRT36	Ability to track and report Drug Rebate amounts by Federal Funding Source.
FRT37	Provides reports with encounter claim payments and eligible counts for Money Follows The Person participants to allow completion of MFP Demonstration Expenditure reports and Proposed Budget Worksheets.
FRT38	Generate a report of reasonable incurred-but-not-reported (IBNR) estimate for Medicaid report on a schedule to be determined by DHSS.
FRT39	Support Payment Error Rate Measurement (PERM) processing, in compliance with CMS quarterly claims sample frequency requirements.

C.5.3.7 Managed Care Enrollment

The Managed Care Enrollment function enables client access to necessary medical care, while at the same time controlling program costs. The FA is required to accept and process the submission of encounter claims from the MCOs.

Objectives for the Managed Care Enrollment Business Area are:

1. Enroll, assign, default, remind, and disenroll clients in and out of appropriate managed care plans.
2. Generate letters to clients.
3. Generate reports to the State.
4. Pay monthly capitated rates to MCOs.
5. Accept and process encounter claims.
6. Process wrap-around service claims, and pay them as fee-for-service.
7. Maintain a repository of basic contract data, networks, benefit packages, capitation rates, encounter, fee-for-service, or wrap-around service claims to be used for contract monitoring and utilization review purposes.
8. Produce invoice and collect premium for the DHCP.

C.5.3.7.1 Contractor Business Responsibilities

Managed Care Enrollment – Business Responsibilities	
MEB1	The Contractor shall perform all functional requirements as needed to support capitated payment for State managed care programs.
MEB2	Accept and process encounter claim data from any State-approved Contractors.
MEB3	Make recommendations for process improvements when possible during the biweekly FA status meeting.
MEB4	Meet all performance expectations related to updates to provider, reference, client data, and adjudication processes within the timeframes specified in Part 11 of the State Medicaid Manual.
MEB5	Update and control enrollment/disenrollment information by establishing a communication mechanism that regularly informs managed care plans of any enrollees or affiliated providers who are no longer eligible timely and accurately.
MEB6	Produce a comprehensive range of essential statistical population reports, membership listings, and reports on membership data at multiple levels including member, managed

Managed Care Enrollment – Business Responsibilities	
	care plan, county, and Statewide.
MEB7	Assist the State to coordinate data from MCO EPSDT encounters and FFS data to assemble the CMS 416 report on April 1 annually and to be submitted by the State.

C.5.3.7.2 Contractor Technical Requirements

Managed Care Enrollment – Technical Requirements	
MET1	Captures enrollee choice of MCO or primary care physician (PCP) and enters into Client record.
MET2	Maintain, track, and report on the number of clients enrolled in each MCO by region and be able to determine what percentage of the total population in the region that each MCO has as enrollment.
MET3	Captures enrollee choice of PCP from the MCO's provider network.
MET4	Assigns enrollee to MCO based on factors such as client age, sex, geographic location; and MCO capitation rate, location.
MET5	Support the automated enrollment of the family members into different and/or the same MCO.
MET6	Provide the ability to select or disregard newly eligible clients for MCO enrollment.
MET7	Displays enrollees associated with MCO.
MET8	Capture, store, and retrieve client-specific enrollment history.
MET9	Provide the ability to associate managed care clients with the capitated plan and program in which they are enrolled. Provide the ability to identify the prepaid membership by benefit package and eligibility category.
MET10	Disenrolls member from MCO.
MET11	Supports the ability to disenroll members without cause during the 90 days following the date of the enrollee's initial enrollment and at least once every 12 months thereafter.
MET12	Automatically disenrolls and re-enrolls members in new plans during periods of open enrollment or when an MCO leaves the program.
MET13	Generates notices to Client of assignment to or disenrollment from MCO.
MET14	Identifies Clients excluded from enrollment, subject to mandatory enrollment, or free to voluntarily enroll in MCO.
MET15	Prioritizes enrollment for Clients to continue enrollment if the MCO does not have the capacity to accept all those seeking enrollment under the program.
MET16	Provides a default enrollment process for those Clients who do not choose an MCO.
MET17	Automatically re-enrolls a Client 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).
MET18	Supports ANSI X12N 834 transaction as required by the Health Insurance Portability and Accountability Act (HIPAA).
MET19	Provide the ability to support multiple managed care models and capitated payment plans.
MET20	Receives and processes eligibility data from State's Eligibility source system.
MET21	Receives MCO contract information from contract data store (e.g., address, covered services, rates).
MET22	Receives and processes provider eligibility data from MMIS or data repository for PCP program.
MET23	Accept MCO assignment and PCP information from the enrollment broker.
MET24	Selects premium payment amount based on client characteristics and generates PMPM payment (e.g., capitation, case management fee) after deducting patient liability amount for

Managed Care Enrollment – Technical Requirements	
	Nursing Facility and Assisted Living clients.
MET25	Provide for monthly capitated payments.
MET26	Supports ANSI X12N 820 transaction to itemize capitation payments as required by HIPAA.
MET27	Transmits enrollment and PMPM payment data to MMIS or data repository.
MET28	Transmits enrollment records and PMPM payments to MCOs.
MET29	Generates identification cards for enrollees or adds MCO/PCP alerts to Medicaid identification cards.
MET30	Perform periodic reconciliation of client eligibility data and enrollment information with managed care plans and identify related PCP for each client.
MET31	Processes premium receipts from Clients.
MET32	Supports inquiries regarding premium collections.

C.5.3.8 Managed Care Organization Interfaces

The Managed Care Organization Interfaces function provides the state with the ability to monitor the effectiveness of comprehensive health care organizations including; Health Maintenance Organizations (HMO), State-regulated MCO, county or locally operated health care organizations, and other models on health outcomes related to the Medicaid Program. It also assists the state with strategic and administrative planning by:

1. Supporting the assessment of members' access to services
2. Facilitating accurate payments to MCO for managed care services provided to enrolled members
3. Receiving, processing, and storing MCO encounter records for use by the Medicaid agency in managing MCO performance.
4. Providing information to support assessing quality and cost of care provided to enrollees
5. Blocking duplicate fee-for-service payments and supplemental payments to providers by identifying services covered under capitation premiums
6. Collecting and reporting on financial data related to Medicaid managed care programs
7. Collecting data and providing reports to support MCO contractor monitoring
8. Supporting specific functions, as applicable, related to the administration of Section 1115 Waivers

C.5.3.8.1 Contractor Business Responsibilities

MCO Interfaces – Business Responsibilities	
MCB1	Create and publish a manual, specifying requirements for the submission of encounter claims and fee-for-service by an MCO or other State-approved Vendors.
MCB2	Maintain a repository of basic managed care plan contracts and contract data in addition to information identifying specific providers and networks, capitation rates, benefit packages, and geographic areas for each plan in order to process encounter data, stop-loss claim records, capitation payments, and retroactive payment adjustments.
MCB3	Thoroughly test and implement new MCOs or State-approved vendors, to include, but not limited to: setting up different tables in the systems, correspondence, coordination with DHSS Policy unit, transition implementation task force.
MCB4	Provide data to actuarial firm chosen by the State for calculation of capitation rates.

MCO Interfaces – Business Responsibilities	
	Provides data for an actuarial firm to use when it calculates capitation rates for the State. The DMES creates extract files containing information related to paid claims, client eligibility, managed care enrollment, and providers.

C.5.3.8.2 Contractor Technical Requirements

MCO Interfaces – Technical Requirements	
MCT1	Captures information on contracted MCOs and other contracted entities, including geographic locations, capitation rates, and organization type.
MCT2	Captures information identifying contracted providers within MCO network, including PCPs.
MCT3	Captures information identifying contracted providers within other contracting entity's network, including PCPs.
MCT4	Provide the capability to accept, store, and process information from the DCIS regarding reimbursement levels.
MCT5	Accepts and processes update information as changes are reported.
MCT6	Captures termination information when an MCO contract or other contractual entity contract is cancelled.
MCT7	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 for MCOs and other contracting entities.
MCT8	Identify and report on all Medicaid direct providers, Medicare providers, and providers affiliated with contracting health plans, including providers of out-of-plan services.
MCT9	Provide the ability to uniquely identify providers that furnish services on a capitated/case management basis and those that provide services on both a fee-for-service and/or a capitated/case management basis.
MCT10	Provides information to support review of new enrollments and to prohibit affiliations with individuals debarred by federal agencies.
MCT11	Provide the ability to ensure and document that all contractors and providers, and their subcontractors, meet all applicable federal facility certification and credentialing requirements.
MCT12	Allow for retroactive enrollment of clients to MCOs, other managed care entities, or other contractual entities. Provide a process to handle retroactive membership additions and terminations.
MCT13	Ensure that providers have access to client eligibility information, including the identity of the managed care plan, primary medical care provider where applicable, and restrictions in coverage, through the use of client identification cards and the EVS.
MCT14	Provide for the timely updating and control of enrollment/disenrollment information by the establishment of communication mechanisms that regularly inform the managed care plan of any enrollees who are no longer eligible.
MCT15	Create a report of terminated providers.
MCT16	Provide the ability to track provider enrollment over multiple plans and track total enrollment by site, system, or plan.
MCT17	Process capitation payments to MCOs and other contractual entities. Calculate capitation payments based upon the number of capitated enrollees within each rate category served by an MCO or other contractual entity during a given time period times the capitation rate for each rate category during that period.
MCT18	Provide the ability to pay capitated payments at provider specific rates by program and allow various capitation rates for each MCO or other contractual entity.

MCO Interfaces – Technical Requirements	
MCT19	Support multiple capitation methodologies including, but not limited to the following: a. Full risk b. Partial risk c. Specialty or ancillary service capitation
MCT20	Incorporate a prospective monthly process and disbursement function that includes, but is not limited to the following: a. Production of capitation payments to MCOs and other contractual entities b. Production of a roster of enrollees assigned to each MCO or contractual entity c. Production of a RA which describes the reason or type of each capitation transaction d. Production of a report that summarizes the amounts included in each unique capitation payment
MCT21	Identifies individuals/enrollees who have terminated enrollment, disenrolled, or are deceased, and excludes those individuals from the monthly MCO or other contractual entity capitation payment.
MCT22	Generates regular capitation payments to MCOs or other contractual entities, at least on a monthly basis in compliance with HIPAA-standard X12 820 Premium Payment transaction where applicable.
MCT23	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).
MCT24	Perform automated adjustments and recoupment of capitated payments. Generate adjustments to post capitation rates based on retroactive adjustments to enrollee or managed care or other contractual entity information including enrollment periods, changes in rate categories, contracted rates, and enrollee death. Produce payment and adjustment authorization for approved capitation payment and case management fees in the required format.
MCT25	Performs mass adjustment to rates according to State policy (e.g., annual adjustment, negotiated rate change, court settlement).
MCT26	Performs periodic reconciliations of State member records with MCO, PCP enrollment records.
MCT27	Performs periodic reconciliations of State member records with other contracted entities, PCP enrollment records.
MCT28	Verifies correct transfer of capitation payment when member disenrolls from one MCO or other contracted entity, and enrolls in another plan.
MCT29	Produce a report for comparing payments made through an 820 with the 834 enrollment roster.
MCT30	Supports ANSI X12N 820 Premium Payment transaction as required by HIPAA.
MCT31	Provide the capability to allow a percentage of the capitation amount to be held back for incentive or other purposes.
MCT32	Identify, bill, receive, and reconcile, by client, insurance premium payments, including ability to Buy-In to employer or State operated insurance plans (for example, Delaware Healthy Children Program) and allow for client co-pay based on a sliding scale of ability to pay.
MCT33	Collects and stores encounter data on a periodic basis.
MCT34	Applies key edits to encounter data (e.g., contractual entities, physician, member ID numbers; diagnosis and procedure codes). (Note: The encounter record edits can be different from claims edits.)

MCO Interfaces – Technical Requirements	
MCT35	Provide for processing of crossover claim records for clients enrolled in LTC MCO or other contractual entity, as appropriate.
MCT36	Perform edits and audits on encounters to ensure integrity and allow for the pricing of the encounters.
MCT37	Provide the ability to apply edits/audits which prevent claim records from being paid when managed care program clients or other contractual entity clients receive plan covered services from sources other than the capitated plan in which they are enrolled. Provide the ability to deny normal fee-for-service claim records for covered services rendered by capitated plans, and identify, edit, and correctly adjudicate fee-for-service claim records for services not covered by a specific plan.
MCT38	Returns erroneous encounter data for correction.
MCT39	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
MCT40	Accepts and processes encounter claims in formats as mandated by HIPAA, e.g., X12N 837.
MCT41	Support "stop loss" provisions as defined by the State.
MCT42	Provide a repository of encounter claims information for each managed care plan or other contractual entity and compile average cost per eligible month for each eligibility group. Ensure all federal reporting requirements based on data from encounter records are met (such as family planning sterilization, hysterectomies, pregnancies, EPSDT, immunizations).
MCT43	Accept and capture encounter data including shadow claims, fee-for-service claims for services not included in capitated payment. The claim records should be viewable online.
MCT44	Produce reports for services outside of the capitation agreements for which fee-for-service claim records are received and processed.
MCT45	Accesses and reports on encounter data for the purpose of monitoring appropriateness of care.
MCT46	Provide access to data to support the development of health services delivery standards/practice guidelines that can be used in the ongoing monitoring and measurement of health plans’ performance in the delivery of services, in providing members access to health care, member satisfaction, membership stability and demographics.
MCT47	Provide “report cards” comparing case mix and outcomes of providers and contractors or MCOs or other contractual entities on key performance indicators.
MCT48	Maintain capitation/case management rate data with online inquiry and update capabilities.
MCT49	Provide the ability to establish capitated risk and incentive pools for MCOs, including those who maintain low capitation rates, reduced utilization and costs, and increased preventative care.
MCT50	Build and maintain a database(s) of client data/enrollments in contracted MCOs and other contractual entities to be used for assessing quality and cost of care.
MCT51	Maintain client enrollment history for use in assessing cost and quality of care.
MCT52	Maintain client enrollment history for case management/capitation/premium computations.
MCT53	Produce a comprehensive range of essential statistical population reports, membership listings, and reports on membership data at multiple levels including member, managed care plan, other contractual entity plan, county, and Statewide.
MCT54	Accesses and reports on encounter data for use in profiling MCOs or other contractual

MCO Interfaces – Technical Requirements	
	entities and comparing utilization statistics.
MCT55	Collects and sorts encounter data for use in completing MSIS reports.
MCT56	Collects and sorts encounter data for use in determining capitation rates.
MCT57	Processes encounter data to detect under-utilization of services by enrollees of the MCO or other contractual entity.
MCT58	Compares FFS claims statistics and encounter data, re: cost of care, timeliness of care, quality of care, outcomes.
MCT59	Provide the capability to calculate and pay case management fees paid for each managed care or other contractual entity enrollee assigned to them for up to the limitations specified by the State.
MCT60	Calculate and pay incentive fees based on the savings realized over payments made for services to equivalent enrollees without case managers.
MCT61	Allow the same provider to be paid fee-for-service, case management, and capitation concurrently for different enrollees/clients.
MCT62	Accesses encounter data to identify persons with special health care needs, as specified by the State.
MCT63	Produces reports to identify network providers and assess enrollee access to services.
MCT64	Is able to produce managed care program reports by category of service, category of eligibility, and by provider type.
MCT65	Identify and report on clients who are enrolled in a managed care program, or other contractual entity, based on criteria established by the State. Ensure, as appropriate, that each client's cost/utilization data is linked to his/her MCO or other contractual entity.
MCT66	Produce periodic reports of age-sex capitation distribution by MCO or other contractual entities.
MCT67	Generate monthly 834.
MCT68	Provide the ability to ensure that third party insurance information is regularly exchanged with the managed care plans or other contractual entities.
MCT69	Capture HEDIS-related data and data related to other performance measures, and provide reports based on this data as directed by the State.
MCT70	Provide the ability to produce notices, track notices, and track contact with clients.
MCT71	Produce and generate reports required by the State, to include but not be limited to: a. Monthly enrollment rosters b. Notification of enrollment changes c. Utilization expense analysis per member, per month d. Individual physician, network, and group performances versus identified indices e. Pharmacy claim data by MCO f. Provider report cards indicating provider peer group comparison reports with deviations identified g. Monthly reports on membership data at multiple levels, including member, managed care plan, other contractual entity plan, county, and Statewide h. Reports to assist in ensuring that MCOs or other contractual entities satisfy EPSDT requirements for enrolled clients i. A detailed list of all Managed Care and other contractual entities providers j. Amount and type of services provided by capitated plans to enrolled clients, as reported on encounter forms k. Notification to MCOs and other contractual entities of the amount and effective dates of patient payment amount whenever approved or changed

MCO Interfaces – Technical Requirements	
MCT72	Allows FFS payment to providers for services carved out of the MCO or other contractual entity benefit package. (These services are usually delivered by providers external to the MCO or other contractual entity.)
MCT73	Generates reports of capitation payment by various categories (e.g., by eligibility group, rate cell).
MCT74	Generates FFS claims reporting for services furnished outside of a capitation agreement (i.e., for services "carved-out" of the managed care program).
MCT75	Collects basic administrative information, for instance: a. The identification of an MCO or other contractual entity b. Contract start and end dates c. Contract period/year d. Capitation effective date e. Maximum enrollment threshold f. Enrollee count g. Member month h. Re-insurance threshold
MCT76	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 clients who would be ineligible for Medicaid in the absence of the State's 1115 Waiver).

C.5.3.9 HCBS Waivers

The objectives of the HCBS Waiver business area are:

1. Control enrollment of participants into the HCBS (1915(c)) waiver programs to meet the State's objectives.
2. Enroll traditional and nontraditional service providers meeting identified standards of care into the program to provide services to the target population.
3. Provide services as described in the individual's approved plan of care.
4. Process waiver provider claims and make timely and accurate payments.
5. Produce program data necessary to satisfy Federal Medicaid reporting requirements, monitor utilization, and assess quality of care provided to participants.

C.5.3.9.1 Contractor Technical Requirements

HCBS Waiver – Technical Requirements	
WAT1	Identifies unduplicated participants enrolled in 1915 (c) waiver program.
WAT2	Tracks and reports the number of unduplicated participants in the 1915 (c) waiver program.
WAT3	Maintain information for Home-and Community-Based Waiver Services (HCBS) program recipients, including prior placement and tracking of services and expenditures.
WAT4	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.
WAT5	Identifies the date a participant is assessed to meet the waiver level of care (LOC) and the date of the LOC reevaluation.
WAT6	Captures enrollment information, including National Provider Identifier (NPI) and support atypical provider numbers on entities or individuals meeting the qualifications contained in the provider agreement including geographic locations and capitation or Fee-for Service

HCBS Waiver – Technical Requirements	
	(FFS) rates.
WAT7	Prevents enrollment of entities and individuals who do not meet the provider qualifications contained in the provider agreement.
WAT8	Updates information as changes are reported.
WAT9	Captures termination information when a waiver provider voluntarily terminates or a provider agreement is cancelled.
WAT10	Prohibits enrollment of providers affiliated with individuals debarred by State or federal Agencies, listed in Abuse Registries, or otherwise unqualified to provide service.
WAT11	Store the plan of care and make it available for viewing.
WAT12	Produces monitoring reports to determine if services approved in the plan of care are provided.
WAT13	Identifies the date a participant's plan of care (POC) assessment is completed and the date of the next POC re-evaluation, if applicable.
WAT14	Support automated letter generation functionality.
WAT15	Processes claims for State plan, MFP and waiver services.
WAT16	Applies edits to prevent payments for services covered under a waiver program to a Medicaid provider who does not have a provider agreement.
WAT17	Prevents or suspends payments for Beneficiaries who have become ineligible for Medicaid.
WAT18	Suspends payments for waiver services furnished to individuals while they 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.
WAT19	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 where applicable.
WAT20	Support the identification of clients enrolled in the Money Follows the Person program to ensure that claims can be charged to either Medicaid or the MFP grant as appropriate.
WAT21	Edits waiver services claims for prior authorization, if applicable.
WAT22	Edits waiver services claims for Third Party Liability (TPL) coverage prior to payment to ensure Medicaid is the payer of last resort.
WAT23	Edits waiver services claims for Beneficiary cost share of premium or enrollment fees prior to payment.
WAT24	Gathers data and produces a variety of financial reports to facilitate cost reporting and financial monitoring of waiver programs.
WAT25	Monitor and report expenditures for all Medicaid program services, Money Follows the Person (MFP), and waiver services.
WAT26	Provide the ability to create all required HCFA-372 report data for HCBS waiver program.
WAT27	Separate out services to MFP clients on all appropriate reports.
WAT28	Automatically generate data and reports for the MFP program to support CMS Disabled & Elderly Health Programs Group (DEHPG) system reporting.
WAT29	Generate quarterly, semiannual, and annual reports for the MFP Grant.
WAT30	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.
WAT31	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.
WAT32	Monitors provider capacity and capabilities to provide waiver services to enrolled participants.

C.5.3.10 Immunization Registry Interfaced

The objectives of the Immunization Registry Interfaced are:

1. Meet federal reporting requirements for reporting vaccination rates for Medicaid children enrolled in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.
2. Ensure the privacy and security of immunization information in transit and at rest.

C.5.3.10.1 Contractor Business Responsibilities

There are no Contractor operational responsibilities to perform. The Division of Public Health (DPH) owns and operates the registry.

C.5.3.10.2 Contractor Technical Requirements

Immunization Registry – Technical Requirements	
RIT1	Collects and maintains claims history for vaccinations at the Client-specific level until the Client is 20 years of age.
RIT2	Identify, maintain, update, and provide access to data on all children, including non-Medicaid, eligible for the VFC Program.
RIT3	Accept, identify, maintain, and process claim records from providers participating in the VFC program via the DPH Registry.
RIT4	Provide capability to easily add, change, and delete procedure codes, with associated effective and end dates, for coverage under the VFC Program.
RIT5	Interfaces with a statewide automated immunization registry and allows regularly scheduled data exchanges. a. Populates the statewide automated registry to fully populate the registry with Medicaid children b. Populates the statewide automated registry with Medicaid claims for children receiving immunizations
RIT6	Sends, at a minimum, the following information to a statewide immunization registry through the interface: a. Medicaid identifier b. Demographic information c. CPT/billing procedure code d. Identify rendering service provider e. Reminder/recall notice dates
RIT7	Maintain a second Provider Registry File that will carry the non-Medicaid provider data. This data should be collected from VFC records submitted to the MMIS for non-Medicaid providers.
RIT8	Edits data for data validity, duplicate records and performs quality checks; sends error message if appropriate.
RIT9	Generates letters and/or alerts to parents or guardians of Medicaid children at scheduled intervals.
RIT10	Pay immunization administration fees via the same procedure codes used to identify vaccine costs in the procedure code file.
RIT11	Provide the ability to take a non-Medicaid enrolled provider's name, address, and EIN so that an appropriate IRS form 1099 can be produced.

Immunization Registry – Technical Requirements	
RIT12	Accept and process VFC electronic claims from DPH as follows: a. for Medicaid eligible children in a fee-for-service arrangement, pay the administrative fee b. and for children not eligible for Medicaid, pay the administrative fee
RIT13	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.
RIT14	Correctly allocate all VFC funding and expenditures based on whether they are funded by state only or state and federal funds.
RIT15	Provide the ability for flexible reporting on immunizations as prescribed by DHSS.
RIT16	Measures immunization coverage for the Medicaid population using current EPSDT periodicity schedule.
RIT17	Selects and sends data to the registry at least on a weekly basis.
RIT18	Allows periodic reports to be received and stored within the MMIS Report Repository: a. Provides data exchange to MMIS to satisfy/enhance the Federal EPSDT reporting requirements
RIT19	Provides safeguards as described in the October 22, 1998, State Medicaid Director letter, Collaborations for Data Sharing between State Medicaid and Health Agencies.

C.5.3.11 Customer Service Business Area

The objectives of the Customer Service business area are:

1. Ensure communications with providers and clients are timely, accurate, and consistent.
2. Maintain client information to support claim processing.
3. Flexible automatic generation of appropriate correspondence to providers, clients, and other stakeholders.
4. Perform at Customer Service performance levels to meet industry expectations.
5. Utilize project-wide call tracking, monitoring, and recording capabilities to ensure quality of communications.

C.5.3.11.1 Contractor Technical Requirements

Customer Service – Technical Requirements	
CST1	Establish and maintain toll-free telephone numbers and lines for all call centers.
CST2	Operate interactive voice response system with approved scripts to respond to inquiries using a telephone menu and response system.
CST3	The telephone system must have sufficient capacity to handle all calls each business day.
CST4	Support necessary inbound call hold queues and call center groups.
CST5	Utilize Computer Telephone Integration (CTI) to provide personalized routing and work-object handling based upon identifiers received from the caller regarding language, inquiry area, and ability to produce reports on both electronic and voice transactions.
CST6	Capability to answer calls in FIFO (first in first out) sequence queue, with ability to report statistics, online and print, for all calls in the queue.
CST7	The telephone system must have answering capabilities that will message callers when all operators are busy or the caller has reached the call center during non-business hours.
CST8	Provide a voice messaging option, at the DHSS designated intervals, during the queue hold time.

Customer Service – Technical Requirements	
CST9	Provide the ability to use educational scripts for callers on hold or waiting in the queue.
CST10	IVR system must use efficient menus. Monitor provider feedback to menus and options and make continuous improvements based on State and provider feedback.
CST11	Provide a web feedback tool to process to accept stakeholder feedback and report the results to DHSS through the workflow tool based on DHSS criteria.
CST12	Ability for authorized staff to access interactive voice response system remotely.
CST13	Ability to integrate voice and electronic transactions into a single workflow with integrated queues that allow work blending and load balancing.
CST14	IVR system shall use automated menus, including an easily accessible option for reaching a live operator.
CST15	IVR must utilize separate toll-free telephone numbers for Providers and Clients.
CST16	The Call Center Management System must be able to monitor and provide real-time statistical analysis, reporting and forecasting software for: a. Abandon Rate b. Availability and Agent Utilization c. Average Speed of Answer (ASA) d. Call length e. Contact Volume f. Customer Satisfaction g. Handle Time h. One Call Resolution Rate i. Peak hour statistics j. Identification of historical trends
CST17	Provide the ability to separately record and report call statistics for all call centers (e.g., PBM, Provider, and Client).
CST18	Provide quality monitoring tools and processes to enable a continuous improvement cycle for toll-free call center services that includes silent monitoring capabilities for call center supervisors and approved DHSS staff.
CST19	Record all calls into the call center and retain call recordings, for a period to be determined by the DHSS.
CST20	Provide multiple language options (at minimum English and Spanish) and TTY/TDD services for hearing impaired.
CST21	Provide language translation services for clients who use the Client Help Line and for all written clients inquiries and responses.
CST22	Provide other means of communication assistance (e.g., contracted third party language interpretation services) for three-way interpretation, TDD, TTY.
CST23	Support the ability to re-route misdirected calls to the correct call queue or back to the main menu.
CST24	Provide traffic studies to the DHSS on usage of the toll-free lines designated for client and provider inquiries. All costs related to these studies shall be the responsibility of the Contractor.
CST25	Generate reports to meet Federal and State requirements.
CST26	Maintain an automated call tracking capability for all calls and correspondence received. The system should log and track information for each call such as time and date of call, identifying information on caller (provider, client, caller name, and others), representative ID, call type, call category, inquiry description, customer service clerk ID, ticket status, and response description.
CST27	Include fields in the CRM tool indicating DHSS action/notification of positive comments and negative issues/feedback.

Customer Service – Technical Requirements	
CST28	Link the CRM DHSS notification fields and the workflow tool to automatically route appropriate tickets to DHSS for review.
CST29	Provide the ability to link related CRM tickets.
CST30	Include a free form text field for each CRM ticket for comments and/or resolution.
CST31	Provide for online display, inquiry, and updating of call records with access, including, but not limited to, call type, client number, provider or NPI number, inquirers name, client name, provider name, or a combination of these data elements.
CST32	Provide DHSS staff the ability for local and remote access to the CRM system.
CST33	Utilize CTI to auto-populate CRM screens with caller's basic information and access to contact history
CST34	Ability to navigate from or between CRM screens to other data relevant to the call within the MMIS systems including eligibility, demographics, GIS, and claims history allowing multiple screens to display at one time.
CST35	Ability to store the caller's preferred method of communication, including need for deaf or foreign language interpretation.
CST36	Ability to view related correspondence records from a single correspondence record.
CST37	Ability to upload attachments to correspondence records on a daily basis.
CST38	Accommodate searches on call center records by characteristics such as call type, category, CRM number, name of Provider, Provider number, contact name, client ID, other entity names, service authorization number, category of service, user ID, and any combinations thereof.
CST39	Generate ad hoc and standard reports for incoming and outgoing correspondence.
CST40	Link scanned images to correspondence and records to provide one view of all related material (e.g., images, letters, interactions, and tracking number).
CST41	Generate all necessary letters as directed by DHSS.
CST42	Receive, scan, and initiate a workflow for all correspondence.
CST43	Provide the functionality for Customer Relations to initiate client correspondence within 1 business day of receipt or as determined by DHSS.
CST44	Outgoing letters utilize barcodes or other automated tools for faster indexing upon return.
CST45	Generate identification cards to eligible clients and generate replacement cards upon request.
CST46	Revise all forms and documents as program parameters change or experience shows modifications are required.
CST47	Send a client brochure to all heads of households regarding pharmacy changes. Included in the notification an 800 number to call for pharmacy questions. Distribute an easy-to-carry pharmacy benefits information card to reinforce the use of the client pharmacy call center 800 number.
CST48	Allow a user to generate a letter immediately and be able to print locally.
CST49	Implement a system process for system-generated letters to clients and providers based on status in the workflow management queue. For example, the system would generate second notices to providers who have not returned the required documentation.
CST50	Letter templates, including DHSS letterhead and signature blocks, must be easily updated using a standard user interface.
CST51	Incorporate mandatory functionality so the system will allow users to insert free form text as necessary. Free form text should not be limited in size. This functionality must be limited to authorized DHSS users. Support alternate language for free form text correspondence supporting English and Spanish.
CST52	Produce letters for mass mailings using multiple designated addresses.
CST53	Provide a system that must allow for retrieval and reproduction of all generated letters,

Customer Service – Technical Requirements	
	including the address(es) to which the letter was sent and the dates they were mailed.
CST54	Provide a system that must incorporate functionality to define populations that receive correspondence based on DHSS defined attributes for clients and providers, such as health plan enrollment, program participation, Aid Category, Category of Service, age, or geographic location/region.
CST55	Provide a system that must incorporate security rules to control who may issue each kind of letter, and to designate and enforce a chain of review for certain letter types.
CST56	Provide system functionality that must be able to generate client notifications in a manner that meets the needs of the visually impaired as specified by DHSS policy, e.g., Braille, large-fonts, and recordings.
CST57	Provide ability to produce notices in the language of the client, based on the language indicator on the eligibility file. Note: These notices are pre-approved translations of form letters. The system must select the correct language for the client when producing the notice.
CST58	Provide the functionality to send letters by mail, email, web portal inbox, or fax. All mailings will utilize postage class as specified by DHSS.
CST59	Provide the functionality to send letters to multiple or alternate addresses.
CST60	Provide version control of all letter templates.
CST61	Send Certificate of Creditable coverage to clients or former clients.
CST62	Update Provider/Client Operations Manual revised monthly published quarterly and reviewed annually.
CST63	Update User Manuals revised monthly published quarterly reviewed annually, with approval from the State.
CST64	Generate correspondence including informational notices and newsletters in a medium specified by DHSS. For example, hard-copy, email, portal inbox, etc.
CST65	Train Contractor staff, State staff, providers, provider staff and others on policy through the use of a Computer-Based Training (CBT) tools such as a Learning Management System (LMS).
CST66	Provide for simple creation of computer-based courses: a. Allow upload of courses from any word processor that can generate HTML formatting b. Allow display of HTML-formatted text, graphics, sounds and audio-visual presentations c. Allow multiple-choice quizzes at regular intervals, and provide feedback based on user responses d. Allow graded testing for all courses e. Give instructions and help to users taking the CBT courses
CST67	Provide for enrollment of individuals in computer-based courses: a. Track each person's enrollment in one or more courses b. Allow for enrollment in one course based on other courses as a prerequisite c. Allow secure and unique entry of users into their prescribed courses d. Allow users to take courses more than once; to review sections of a course, and to stop and start, picking up at the place where they left off
CST68	Provide reporting on test questions, course progress and completion: a. Allow those completing a course to print a certificate of completion b. Allow training managers to view reports that show overall course status; who has passed, who has failed, who has started but not finished, and who has not started a course c. Allow reports on individual test questions to determine validity and reliability and to help improve course content

D ATTACHMENT D: DMES SYSTEMS OPERATIONS AND MAINTENANCE TASKS

D.1 Approach to System Maintenance and Enhancements

D.1.1 Overview

The Contractor shall be responsible for coordinating and performing "routine maintenance," modifying, making changes, and updating the DMES throughout the term of the Contract. This Section of the Statement of Work (SOW) describes:

1. How System Support Services related to future changes or improvements for to the DMES will be categorized, defined and managed.
2. How Contractor programming hours are defined and allocated and how DHSS and Vendor responsibilities are defined.
3. Future changes and improvements to the system will be defined according to one of three categories:
    a. **Maintenance:** – Shall be defined as software error correction, error resolution, data element value changes, general system maintenance and operation functions, prevention activities, corrective actions, and the adherence to state technology standards.
    b. **Enhancement:** These changes are defined as modifications which change the functions of software and hardware beyond their original purposes and design.
    c. **Major Enhancements (Projects):** These are large scale system changes that have a scope that requires separate budgeting and management. These projects typically will have separate contract amendments that include a detailed scope of work and deliverables.

D.1.2 Change Control Process

A change control (CC) process must be in place for all maintenance and enhancements. All changes must be tested, approved, documented, validated, and version controlled. The Contractor must operate a CC system to monitor and track all system changes. The requirements for the CC process are detailed in Attachment C – DMES Functional Requirements, Section 3.8.

Enhancement and maintenance change controls may be initiated by DHSS or the Contractor. All change requests will be prioritized and approved (or denied or modified) by the DHSS.

Maintenance and Enhancement support activity must include the SDLC Stage activities, which are:

a. Define requirements.
b. Design Approaches.
c. Develop Technical Specifications for the selected design.
d. Develop a Test Plan.

e. Perform Documentation Creation or Updates.

f. Test module modifications and rules engine.

g. Perform Systems Integration Testing.

h. Perform acceptance Test, including regression testing.

i. Obtain approval of Acceptance Test.

j. Perform Beta Testing (not required for all changes).

k. Migrate to Production environment.

l. Perform verification of successful implementation.

The Contractor must provide a preliminary assessment in writing to all enhancement and maintenance requests showing level of efforts and schedule within 10 business days of receipt, unless specified in the CC (which may reduce that time frame) or for large project planning (which may increase that time frame). The response shall consist of a preliminary assessment of the effort (number of programmer and business analyst hours) required to complete the change by SDLC stage. The contractor must work with DHSS to determine due date, impact, and relationship of change to other maintenance and enhancements so that appropriate priority can be assessed.

DHSS at its sole discretion may or may not choose to pursue enhancement and maintenance requests and will prioritize the change control. When DHSS chooses to pursue an enhancement or maintenance request a formal design estimate must be prepared by the Contractor. This estimate will define the problem to be addressed; propose a solution; and specify an estimated level of effort (number of hours) and anticipated schedule required to design, code, test, and implement the change, then approve or revise the request, assign a priority to it, and establish an expected completion date. Additional services may be requested by DHSS and shall be provided on a time and materials, per diem, or other mutually acceptable financial basis as negotiated by project or activity. These activities are anticipated to be in support of State health care initiatives, and may include clerical support to eliminate DHSS backlogs and outreach efforts.

The Contractor shall also be responsible for reporting monthly to DHSS all systems changes that have been implemented in the month. The report shall also include forecasts of CC requests with anticipated implementation dates.

D.2 System Support Services

The Contractor will be responsible for ongoing module and system component maintenance of the DMES. The cost for providing ongoing systems maintenance, including machine time, man-hours, and documentation, must be included in the fixed price proposal bid for each Contract operations year.

The support services requirements cover the warranty and ongoing support that the Contractor will provide for software and system components installed as part of the Delaware Medicaid Enterprise System (DMES). The Contractor is also required to notify DHSS immediately as software errors are discovered.

D.2.1 Maintenance Definition

Typical maintenance tasks are defined as:

1. **Software Error Correction and Problem Resolution:** The process of "fixing errors or defects that preclude full system functionality and operability as prescribed by technical and operational requirements in the Request for Proposal (RFP), the Contractor's proposal, Design Documents or succeeding executed amendments and/or approved SOWs where the work and functionality have been previously defined and paid for in total."

2. **Data Element Value Changes:** Adding, changing, or deleting of data element values incorporated in the source code or used by the source code. To the extent that existing edits and audits use values contained in the source code (compile-able code or "hard-coded"), changes, including deletions and additions to the valid values in the source code, will also be considered "routine" maintenance.

3. **General System Maintenance:** Activities to keeping the DMES operationally efficient and capable of operating to the standards and conditions in which it was approved.

4. **Preventive or corrective action(s):** – Activities necessary to guarantee/ensure the integrity and timeliness of data, error-free application processing, and the adherence to performance standards for both hardware and software.

5. **State Technology Standards:** – Maintain best practices adopted by the Department of Technology and Information (DTI), through the Technology and Architecture Standards Committee (TASC). The Contractor will develop solutions using architecture, software and hardware deemed to be in a Standard or Acceptable category by DTI. When an architecture, software, or hardware is moved to a category of discontinue the vendor must develop a plan to move to a solution considered Standard.

D.2.2 Examples of Maintenance Functions

Examples of functions DHSS considers to be general maintenance include:

1. Maintenance of password and IDs.

2. Data security functions.

3. Maintenance of electronic claims receipt and Remittance Advice distribution.

4. Scheduled ongoing tasks to ensure system tuning, performance, response time, database stability, and processing.

5. Updates to software or other system components requiring version updates, manufacturer "patches," and other routine manufacturer updates to software.

6. Upgrading server operating systems that are deemed to be in decline by State standards

7. Modifying system architecture to comply with state technical architectural standards.

8. Addition of new values and changes to existing system tables and conversion of prior records, as necessary.

9. The maintenance of current system documentation, user documentation, and all program libraries.

D.2.3 Support Services Requirements

The System Support Services requirements cover routine maintenance, software modifications, changes, updates, and general system maintenance to the system. It can be anticipated that changes to healthcare standards and policies will be made during the lifecycle of the DMES. The requirements detail the process for changes from request to acceptance.

The Contractor must meet the following system support requirements:

System Support Services Requirements	
Ref #	**Requirement**
GBB27	DMES shall include ongoing support services and assurance that all regulatory requirements will be met for the Division.
GBB30	All system modifications and changes to the DMES must be processed through the formal change control process.
GBB35	Perform routine maintenance of the system including: a. Notifying DHSS immediately as software errors are discovered b. Perform routine maintenance of the system at no charge to DHSS and not through use of the system modification and change process c. Log and track system errors/defects through a defect tracking tool

D.2.4 Error Prioritization

The Contractor will be required to notify DHSS immediately as software errors are discovered. The Contractor will be responsible for coordinating and providing “routine” maintenance of the DMES at no charge to DHSS and not through use of the system modification change control process. Instead, certain coding changes and system errors/defects will be logged and tracked through a Defect Tracking Log. DHSS will prioritize Priority 1 and Priority 2 errors for the contractor to begin work on immediately. The Contractor must resolve all errors within the following timeframes:

1. Priority 1 Errors (Critical Errors with no workaround): Within 24 hours.
2. Priority 2 Errors (Critical Errors that inhibit full functionality but can be managed in the short-term with some manual intervention): Within 5 business days.
3. Priority 3 Errors (Non-critical errors which do not allow the system to function as designed): Within an agreed upon schedule between the Contractor and DHSS. This will be measured on a schedule defined by DHSS.

D.3 Enhancements

When it is determined that modifications or changes to existing software and hardware significantly improve functionality and performance of the DMES, the Contractor, in coordination with the appropriate subcontractors, shall make such modifications or changes as directed by the DHSS. The Contractor shall be responsible for coordinating and performing software and hardware modifications or replacement for all modules and component parts of the DMES after its implementation, as requested by DHSS.

D.3.1 Enhancement Definition

Typical enhancements are defined as:

1. Software or hardware changes to meet new system functions or requirements beyond a system components capability or purpose that was not originally approved.
2. Software or hardware changes to meet new operational levels beyond what was originally approved.
3. Software or hardware changes to meet new performance levels beyond what was originally required.

D.3.2 Enhancement Tasks

Examples of Enhancement tasks include:

1. Implementation of new module or system component capabilities.
2. Activities necessary to meet new or revised Centers for Medicare and Medicaid Services (CMS) or other federal requirements.
3. Changes to established report, screen, or file formats, such as sort sequence, new data elements, or report items.
4. Implementation of new edits and audits not previously contemplated in the proposed DMES.
5. Changes in processing logic to improve performance.

D.3.3 System Enhancement Requirements

The Contractor must meet the following system maintenance and enhancement requirements:

System Enhancement Requirements	
Ref #	**Requirement**
GBB28	Delaware Department of Health and Social Services (DHSS) is requiring 25,000 hours of staff time per state fiscal year to apply towards system modification and changes to the Medicaid Enterprise once the system has been fully implemented.
GBB29	Contractor shall provide a single fully loaded hourly rate which will apply to change control approved work, as well as to future customization. (See Attachment K, Schedule F)
GBB30	All system modifications and changes to the DMES must be processed through the formal change control process.
GBB31	The Vendor must respond, in writing, to requests from the DHSS for estimates of system modification efforts and schedule within 10 business days of receipt, unless specified in the Customer Change (CC) (which may reduce that time frame) or for large project planning (which may increase that time frame). The response shall consist of a preliminary assessment of the effort (number of programmer and business analyst hours) required to complete the change by System Development Life Cycle (SDLC) stage. Additionally, externally funded projects will require additional staff and will run in parallel so as to not impact enhancement work.
GBB32	DHSS may or may not choose to pursue certain modification requests. For those DHSS chooses to pursue, the Vendor must prepare a formal design estimate. This estimate will define the item to be addressed; propose a solution; and specify an estimated level of effort (number of hours) and anticipated schedule required to design, code, test, and implement the change, then approve or revise the request, assign a priority to it, and establish an expected completion date. Additional services may be requested by DHSS and shall be provided on a time and materials, per diem, or other mutually acceptable financial basis as negotiated by project or activity. These activities are anticipated to be in support of State health care initiatives, and may include clerical support to eliminate DHSS backlogs and outreach efforts.
GBB33	The Vendor shall also be responsible for reporting monthly to DHSS Project Managers all

System Enhancement Requirements	
Ref #	**Requirement**
	systems changes that have been implemented in the month. This monthly report will also include a three-month projection of the CC requests that will be implemented in each month. Major projects requiring more than three months to complete will also be noted, with a status update on project milestones.
GBB34	Vendor must maintain documented version control procedures that include the performance of regression tests whenever a code change or new software version is installed, including maintaining an established baseline of test cases to be executed before and after each update to identify differences.
GBB36	Provide support for system modifications, changes, and updates including: a. Statement of understanding in writing within 10 business days of receipt of Change Control (CC) b. Contractor must report status of each CC timely and accurately as part of the change control process as required and requested by DHSS c. CCs must be completed by agreed upon date d. Updated documentation as specified by DHSS related to CC implementation including but not limited to system, user, training, or other online documentation must be provided to DHSS within 15 calendar days of CC implementation

D.3.4 Systems Team Staffing/Programming Hours

The Contract provides for 25,000 additional staff hours above the base Contract to address prioritized enhancement change control work or work that is part of a larger project and not inclusive under the definition of maintenance.

The Contractor will be responsible for full-time staff support comprised of professional systems engineers (programmer/analysts) for system maintenance and enhancement categories. The Contractor must identify system modification and enhancement staff to be assigned to modification and enhancement projects. Additionally, the staff can be assigned to support general maintenance activities with the approval of the DHSS.

The Contractor will provide a monthly report of time spent by job category and position. At the end of each State fiscal year the Contractor will provide an accounting of the hours spent by job category and position during that fiscal year. If the total falls below the minimum, those hours will be added to the 25,000 programming hours scheduled for the next year. Hours used in excess of the 25,000 hour annual allocation may be credited to any successive year's unused balance or funded through execution of a Contract amendment. At the end of the Contract, the Contractor and the DHSS will review the total hours spent versus the minimum commitments. If the Contractor fails to meet the minimum hours the Contractor will refund the balance of hours to DHSS.

Qualified staff must be available to support system CC requests authorized by DHSS. It is DHSS's expectation that all Service Level agreements (SLAs) associated with routine maintenance, software modifications, and change and enhancement requests will be met and that the work will be accomplished within the budgeted effort. In addition, it is DHSS's expectation that all 25,000 programming hours will be expended in each Contract year.

D.4 Major Enhancements (Projects)

D.4.1 Major Enhancements (Projects) Definition

Major Enhancements are typically significant changes necessary to meet new or revised Centers for Medicare and Medicaid Services (CMS) or other federal requirements. The scope of the major enhancements is typically broad, contains complex requirements, impacts multiple systems, and requires a significant level of effort to complete.

DHSS shall at its discretion determine whether the enhancement will be performed under the terms of the Contract's firmed fixed price which contains a provision for additional programming hours or through an amendment as the funding source. Some major program initiatives are eligible for enhanced federal funding and may require a CMS prior-approval through an Advance Planning Document Update (APDU) prior to project start. APDs usually require a dedicated project management process and funding stream. To accommodate this, DHSS will request a proposal from the contractor for these services. DHSS will be responsible for the production of all APDUs. It is DHSS's expectation that most modifications, changes, and updates will be met under the terms of the Contract's firmed fixed price.

D.4.2 Project Management

All enhancement activities provided through an amendment to the contract will be required to adhere to standard project management methodologies. All enhancement activities will be managed through the change control request process. Specific project scope and deliverables will be detailed in the enhancement request.

D.5 Coordinating Legacy and DMES updates

Modifications, changes, and updates are made through a process of Change Control (CC) requests. As of the start date of this Contract, there will be an existing workload of CC requests that will be applied to the legacy DE MMIS by the current contractor. As new change orders for the legacy MMIS are implemented, the DMES Contractor must participate in the Change Control Board (CCB) meetings with the State and incumbent Fiscal Agent (FA) to determine if the changes in the legacy system include new business and technical functionality that were not communicated in the requirements for the new DMES. During the Design, Development, and Implementation (DDI) process, the Contractor will have access to the incumbent FA’s proprietary change management software (called TIMES®) to monitor the change requests, track status and progress of change orders on open/closed requests and prioritized items as they apply to the DMES.

D.6 Project Help Desk Staff Requirement

Contractor Help Desk expertise is critical to the successful operation of the system. The State seeks efficient use of contracted staff time. Therefore, the staff proposed for this function does not need to be dedicated exclusively to this role. However, the State expects the contractor to maintain live phone and email helpdesk support during state business hours at an appropriate level to provide same day review and next steps for issue resolution. Identify in the staff resumes if they will provide exclusive or part time support of the helpdesk. Where appropriate the department’s Help Desk will provide first-level support. This generally includes resolution of issues such as network connectivity, application log in problems and general PC advice. Contractors normally provide second-level support for more system-specific issues that require application expertise. Issues that require situational, operational or policy interpretation may be

referred to third-level divisional support for Subject Matter Expert (SME) expertise. The contractor should present a helpdesk solution that is appropriate for the proposed system architecture and that most efficiently supports users.

E ATTACHMENT E: DELIVERABLES

E.1 Deliverable Formats

This section of the Statement of Work (SOW) contains the minimum requirements for the Deliverables defined in SOW Attachment B, Statement of Work.

The minimum requirements defined in Attachment E – Deliverables are based on artifacts defined in the Project Management Institute's (PMI) Project Management Body of Knowledge® (PMBOK, 2000 Edition), ISO/IEC 12207, MIL-STD 498, and the State Medicaid Manual.

The Deliverables presented in this Attachment are intended to define the minimums needed for successful execution of the Project; however, the Contractor may propose alternative deliverables and deliverable outline structures if such items more closely conform to the Contractor's software life cycle. Deliverables noted with an asterisk (*) shall be approved prior to commencement of other systems development tasks. All proposed alternatives must be approved by DHSS prior to their use.

Summary of Deliverables

Task	Task Description	Del #	Deliverable	Section No.
1	Project Management			
		1.1	Project Plan	1.1
		1.2	Project Plan Updates	1.1
		1.3	Change Management Plan	1.2
		1.4	Software Development Methodology	1.3
		1.5	Project Repository	1.4
		1.6	Project Status Reports	1.5
		1.7	Security Policies and Procedures	1.6
		1.8	Business Continuity Plan – V1: Development	1.7
2	Detailed Requirements Analysis			
		2.1	Detailed Requirements	1.8
3	Design			
		3.1	Detailed System Design Version 1	1.9
		3.2	Implementation Plan – Version 1	1.10
		3.3	System Architecture and Design Documents a) Interface Detail Design (IDD) and Integration Specification document b) Interface Control Document (ICD)	1.11
		3.4	Architectural Review Board	1.12
		3.5	Test Management Plan	1.13
		3.6	Network Upgrade Requirement	1.14
		3.7	Data Conversion Strategy	1.15

Task	Task Description	Del #	Deliverable	Section No.
4	Development			
		4.1	Development Environment *	1.16
		4.2	Code Library – Version 1: Test Environment *	1.17
		4.3	Development Test Results *	1.18
		4.4	User Manual – Version 1 *	1.19
		4.5	Operating Procedures – Version 1 *	1.20
		4.6	Detailed System Design Version 2	1.9
5	Data Conversion			
		5.1	Data Conversion Plan	1.21
		5.2	Conversion Test Results *	1.22
6	Acceptance Testing			
		6.1	Test Environment *	1.23
		6.2	Acceptance Test Plan *	1.24
		6.3	Acceptance Test Results *	1.25
		6.4	Operational Readiness Testing Plan*	1.26
		6.5	Operational Readiness Test Results*	1.27
		6.6	Source Code Library – Version 2: Acceptance Testing Environment *	1.17
		6.7	Business Continuity Plan for Systems Operations and Maintenance	1.7
		6.8	Detailed System Design Version 3	1.9
7	Training			
		7.1	Training Strategy *	1.28
		7.2	Training Plan *	1.29
		7.3	Training Environment*	1.30
		7.4	Training Materials*	1.31
		7.5	Training Report*	1.32
8	Implementation			
		8.1	Implementation Plan – Version 3*	1.10
		8.2	Production Environment *	1.33
		8.3	Source Code Library – Version 3: Production Environment *	1.17
		8.4	User Manual – Version 2	1.19
		8.5	Operating Procedures – Version 2*	1.20
		8.6	System Documentation)	1.9
		8.7	Implementation Certification Letter	1.34
9	Operations			
		9.1	Operations Quality Management Plan	1.35
		9.2	Fiscal Agent Staffing Requirements	1.36

Task	Task Description	Del #	Deliverable	Section No.
			Capability Report	
		9.3	Weekly Project Status Report	1.37
		9.4	Annual Status Report	1.38
10	Certification			
		10.1	Certification Checklist	1.39
		10.2	Certification Review Package	1.40
11	System Operation and Maintenance Support			
		11.1	System Operation and Maintenance Support Plan	1.41
		11.2	Staffing Requirements Capability Report	1.42
		11.3	Weekly Project Status Report	1.37
		11.4	Annual Status Report	1.38
		11.5	System Updates	1.45
		11.6	Operations & Maintenance Procedures Manual	1.46
12	Operations - Pharmacy Benefit Management Services			
		12.1	Operations Quality Management Plan	1.35
		12.2	Staffing Requirements Capability Report	1.36
		12.3	Weekly Project Status Report	1.37
		12.4	Annual Status Report	1.38
13	Turnover			
		13.1	Turnover Plan	1.45
		13.2	Develop a DMES Requirements Statement	1.46
		13.3	Systems Documentation and Source Code Library	1.47
		13.4	Turnover Results Report	1.48

E.1.1 Deliverables 1.1 and 1.2 – Project Plan

Overview: This section will describe the Contractor's approach to the deliverables that comprise the Project Plan. The Project Plan is developed for the purpose of planning the project and provides a consistent, coherent document that is used to guide both project execution and project control. At a minimum, the Contractor's Project Plan shall include:

- Project Schedule/Work Breakdown Structure
- Risk Management Plan
- Quality Management Plan
- Project Staffing Plan

- Change Management Plan
- Communications Management Plan
- Facilities and Equipment Plan

Version 1 of the Project Plan will be submitted with the Proposal. Subsequent updates to the Project Plan will be submitted according to the requirements defined in Attachment B – Statement of Work, Task 1.

E.1.1.1 Project Schedule/Work Breakdown Structure

During the Planning Phase of the Project, the Contractor will perform scope planning and scope definition tasks that result in a Schedule/Work Breakdown Structure (WBS), as part of the Project Plan. The Contract will be responsible for submitting all project schedules to DHSS in Microsoft Office Project 2007. The project plans must include:

1. Any assumptions or constraints identified by the Bidder, both in developing and completing the work plan.
2. A critical path method (CPM) diagram indicating the interrelationships between sub-tasks and a Gantt chart, showing the duration estimates (planned start and end dates) of each task and subtask in the WBS.
3. The sequence of tasks and the tool or method used to control time spent on the Project.
4. The recording of all major tasks, milestones, and deliverables associated with the Project.
5. Any and all tasks or subtasks that requires more than 80 hours or 10 workdays to complete by either the Contractor or DHSS must show an accurate estimation of the work and resources required to complete the project and must include estimates and budget for costs of each task.
6. A discussion of how the work plan provides for handling of potential and actual problems.
7. A schedule for all deliverables providing adequate review time by DHSS, revision time if needed, and subsequent review time.
8. System design activities that are organized by business area to facilitate requirements traceability and to simplify DHSS resource availability.

During execution of the project, the Contractor shall regularly report the schedule performance index (SPI) and schedule variance (SV) to measure the magnitude of variance from the schedule baseline. The variance analysis shall be performed at the task level, based on the percentage completion of the task and the actual number of hours or days worked on the task. Schedule variance must also be reported to the DHSS. The Contractor must work with the DHSS Project Managers to address any variance in a manner to ensure overall completion of the Project within schedule constraints. DHSS will work with the Contractor to approve fast-tracking or reallocation of resources, as necessary.

During execution of the project, the Contractor must measure performance according to the project plan and manage changes to the project schedule requested by the DHSS. When tasks are complete, the Contractor must seek verbal acceptance from the DHSS for each task, and formal acceptance of each deliverable.

E.1.1.2 Risk Management Plan

During the project Planning Phase, the Contractor shall develop and use a standard Risk Management Plan approved by the DHSS. This section will explain how the Contractor plans to:

1. Address the process and timing for risk identification.
2. Describe the process for tracking and monitoring risks.
3. Describe the governance structure involved in and procedures for identifying and reporting potential risk and risk resolution.
4. Identify the tools and techniques that will be used in risk identification and analysis.
5. Describe how risks will be quantified and qualified, and how risk response planning will be performed.

The Contractor must also explain its approach to reporting any identified risks including:

1. The written evaluation of each risk and potential impact.
2. Establishing a risk ranking or risk priority based on likelihood of occurrence.
3. Assigning risk management responsibility.
4. Creating of a risk mitigation strategy.

For each significant accepted risk, the Contractor must develop and explain its risk mitigation strategies to limit the impact. The Plan must include aggressive monitoring for risks, identify the frequency of risk reports, and describe the plan for timely notification to the DHSS of any changes in risk or trigger of risk events.

E.1.1.3 Quality Management Plan

The Contractor will explain its methodology for employing a formal Quality Management Plan (QMP). During the Planning Phase of the project, the Contractor will identify quality requirements and/or standards for the project and deliverables and document how the project will demonstrate compliance. The plan will be tailored to address the quality tasks and processes associated with the production of deliverables up through the Implementation task for software development. The QMP must follow the prescribe methods of the Project Management Body of Knowledge® (PMBOK) Guide (Fourth Edition). Quality planning must be performed in parallel with other project planning processes and inputs (e.g., change management, WBS, cost and schedule, stakeholder register, risk register, environmental factors and organization process assets) so that as the product or deliverable changes, so do the tools and techniques that monitor and evaluate their performance and quality.

The Contractor must outline acceptance criteria for each phase of the project. The Contractor must develop content checklists and establish performance measures using tools to assess the quality of project deliverables and product delivery. Acceptance criteria must be established well before the start of development of each planned deliverable. The DHSS will review and formally approve the acceptance criteria which shall represent an agreement between the DHSS and the Contractor as to the content of the deliverable. Once the deliverable is received and reviewed by DHSS, the acceptance criteria will be re-used in conjunction with other applicable planning criteria to check and validate the content of the deliverable.

E.1.1.4 Staffing Management Plan

This section describes the organization structure, roles, and responsibilities of the personnel, staffing levels, and other resources that will be utilized to provide successful project management .The Contractor will explain its commitment to staffing by creating a Staffing

Management Plan where resources are identified and are mapped to the allocation in the WBS by name or by type. Staff allotted to a plan must remain on that project for the duration of the project unless changes are authorized by DHSS. The Contractor will be responsible for maintaining the project management staffing plans for the duration of the contract period.

The Bidder will provide a description of the criteria and process used to develop the staffing estimates, criteria and process used to determine staffing qualifications, detailed organizational charts, and a resource-loading chart will be included. This section will include the following information:

1. Staffing Plan, including:
    a. Project Team – Description of the Contractor's project team, including:
        1) Delivery of the labor categories for all staff to be assigned to the Project.
        2) Position title.
        3) Qualifications for the position (i.e., education, training, and certifications from accredited school or association).
        4) Required skills.
        5) Number of staff to be assigned.
        6) Functions to be performed.
        7) Physical location.
    b. Identification of Named Staff – Description of the Contractor's key persons for the Project, including:
        1) Name.
        2) Position title.
        3) Description of the person's responsibilities within the Project.
        4) Start and end dates.
        5) Level of commitment to the Project (i.e., full-time, number of hours per week, number of hours per month).
        6) Estimated number of hours per task/deliverable.
        7) Organizational reporting.
        8) Physical location.
2. Approach to establishing staffing levels – Description of the Contractor's approach to determining staffing levels for the project, including the criteria and process used to develop the staffing estimates. In addition, the Contractor shall describe its contingency plans for managing the staff and additional staff, if necessary; to ensure that project deadlines are met.
3. Detailed Organizational Charts – Description of the project organization, including DHSS, QA Contractor, and DDI Contractor staff. The charts will show the names and titles of all management staff and will clearly depict the reporting relationships among the project teams and the team members. For each task/deliverable of the Project, the following shall be identified:
    a. Reporting structure for the Contractor's project organization.

b. Named Staff for each task/deliverable, subtask, and activity.

c. Number and Categorized Staff assigned to the task/deliverable, subtask, and activity.

4. Resource Loading Chart – Provide a staffing matrix that indicates the staffing levels for the Project by labor category, and include start and end dates for each task/deliverable, and the physical location of each member.

5. Roles and Responsibilities – Description of the roles and responsibilities of DHSS and the Contractor, as well as the roles and responsibilities of the individual team members.

E.1.1.5 Communications Management Plan

The Contractor will develop and explain its approach to Communications Management. The Communications Management Plan must incorporate processes to ensure timely and appropriate generation, collection, distribution, storage, and retrieval of project information. The plan ensures that the correct individuals receive required information in a timely manner.

In order to ensure that everyone is prepared to send and receive communication in the most effective manner, a plan for managing project communication is required. The plan shall define the information and communication needs of the stakeholders, including; who needs access to project information, what information is needed, when it will be needed, and how the information will be provided to them. At a minimum, the plan shall include an analysis of communication tools (media) and methods, identification of project stakeholders, a communications matrix, the communication protocols and procedures for reporting on project issues, and a methodology for amending the plan.

During the project, the Contractor will execute the plan with agreed upon interval (e.g., weekly) in formats approved by the DMMA. The Contractor is responsible for updating the Communications Management Plan as necessary and throughout all phases of the project until the end of the Contract.

E.1.1.6 Facilities and Equipment Plan

This section shall identify the plan to meet the facilities and equipment requirements indentified in the SOW in Attachment B – Statement of Work, Section 1.11. The facility requirements detail the building size, location, security and special build-out requirements. The Contractor's local facility shall be located as close as possible, within a 15-mile radius of the State offices located at the DHSS Holloway Campus in New Castle, Delaware. DHSS prefers a location convenient to DMMA. Location will be considered in the evaluation process.

The Contractor may perform other Medicaid Enterprise functions, including computer processing, outside of the New Castle, Delaware area, but within the continental United States. All computer processing sites related to the DMES project must be pre-approved by the State. Subcontractors whose work facilities are located separately from the Contractor facility must be approved by DHSS before operations can begin at that location.

The operation of the DMES must be performed at secure facilities that meet the Health Insurance Portability and Accountability Act (HIPAA) privacy and security standards. All facilities handling DMES data must meet or exceed all of the security requirements. Due to limited space at DHSS facilities, the Contractor will need to provide dedicated accommodations for the co-location of State designated project staff and QA Contractor staff.

The Contractor's Facilities and Equipment Plan will address the following but not be limited to:

1. Required functions to be maintained at the local facility such as:

a. Contract Administration/Contract Management.
b. Receive and process paper claims other documents – claims entry.
c. Data entry.
d. Claims processing and suspense resolution.
e. System Maintenance.
f. System Modification.
g. Business operational activities – Mail inbound, check requests, etc.
h. Production of reports, newsletters, manuals, and bulletins.
i. Records storage (paper claims, attachments, letters, etc.).
j. Provider relations, Provider enrollment, Provider training.
k. Provider and Client Relation Call Centers.

2. The provisioning of at least one dedicated meeting room with audio and video equipment (projectors and conference phones) and white boards to accommodate PMO meetings, state staff meeting, and QA Contractor activities.
3. Provisioning, and maintenance of phone and phone lines, email, mail, and Internet services for communication with providers, clients, state staff, MCOs, and other State agencies.
4. Secure climate-controlled onsite storage for archiving all paper documents, based on the retention periods set by the State and for each type of document. Access will be restricted to approved State staff only, as designated by the State.
5. Building and property rent/lease/taxes.
6. Liability insurance for facility and Contractor staff.
7. Security (e.g., access for Contractor, State and QA Contractor staff).
8. Utilities, including power, lights, water, heat/air conditioning, and garbage.
9. Fire alarm and/or suppression systems.
10. Maintenance, including janitorial, landscape, and buildings and grounds.
11. Copiers, faxes, printers, local office equipment.
12. Sufficient restrooms, furnished conference rooms, break areas, coffee/kitchen type areas, to support a project of this size.
13. Building and data center security (alarms, card-key access systems).
14. Data storage, technical library.
15. Help desk and technical support.
16. Reception area.
17. Full compliance with HIPAA Security Rules.
18. PCs and workstations.
19. Provisions for telecommunications for remote work, if applicable.
20. Office supplies for DDI Contractor staff, including storage facility sufficient for all staff.

21. Office furniture (e.g., desks, chairs, file cabinets, wall panels, shelves, and wall clocks).

E.1.2 Deliverable 1.3 – Change Management Plan

Overview: The Contractor shall describe the administrative and technical procedures to be used throughout the software life cycle to control modifications and releases of the software. The plan must address: the recording and reporting of status items and modification requests, the completeness, consistency, and correctness of releases, control and the storage, handling, and delivery of the software. The plan must address initial design, development, and implementation (DDI) as well as ongoing maintenance, enhancement, reuse, reengineering, and all other activities resulting in software products. The Contractor must assist and provide to the State with the acquired insight into, and tools for monitoring, the processes to be followed for change and version control, the methods to be used, and the approach to be followed for each activity. Portions of the plan may be bound separately if this approach enhances their usability.

E.1.2.1 Organization and Resources

This section will describe the organization structure, methodology, roles and responsibilities of the personnel, and other resources that will be utilized in conducting configuration management activities. The section will include the following information:

1. Methodology – The Contractor will describe its change management methodology including: the policy and procedures, tools, and techniques to be applied to configuration management; and the use of and approach to version control during iterative development if applicable.
2. Roles and Responsibilities – The Contractor will describe the change control process with regard to the roles and responsibilities of DHSS and the Contractor related to configuration control activities.

E.1.2.2 Configuration/Change Management Tasks

This section will describe the tasks and activities that will be performed as part of change management. These tasks and activities include:

1. Change Identification – The Contractor will describe the types of items that will be under configuration management control, how the Contractor will set and maintain baselines, when items enter controlled status, how the labeling and numbering scheme is applied to configuration management items, how the identification scheme addresses versions and releases, and which people or groups are responsible for each item.
2. Configuration Control – The Contractor will describe the following:
    a. Change Control – The mechanism for identification, submission, tracking, evaluation, coordination, review, and approval/disapproval of proposed changes to items under configuration management.
    b. System Change Requests – The forms used to report problems or identify changes, and the procedures for using the forms including the method for tracking problems. The Section will also include samples of the forms to be used.
    c. Interface with Other Groups – The interface and relationships between the Contractor's configuration control process, DHSS's Change Control Board (CCB), and other organizations and teams on the Project.
    d. Priorities – The method for prioritizing changes.

e. System Release Management – The plans for releasing deliverables to DHSS including: developing a release procedure, instructions for preparing version description documents, repository establishment, and operation.

f. Version Control – The process to control an identified and documented body of software, including identifying version naming conventions and the configuration management actions required for modifications to a version of software (resulting in a new version).

g. Audit Control – The process to control and audit accesses to items.

3. Configuration Status Accounting – The Contractor shall address the management of records and status reports that show the status and history of controlled software items including baseline. The reports shall include number of changes for a project, latest software item versions, release identifiers, the number of releases, and comparisons of releases. This Section will describe how information will be captured to anticipate common inquiries and provide the information in a form where it is easily accessed. The Section will also include a list of reports with the frequency and distribution.

4. Configuration Evaluation – The Contractor shall describe the process to document the functional completeness of the software against their requirements and the physical completeness of the software items (whether their design and code reflect an up-to-date technical description).

5. Release Management and Delivery – The Contractor shall address the control of the release and delivery of software products and documentation. This Section will describe the archive and retrieval process and the retention schedule for archived items, noting that master copies of code and documentation shall be maintained for the life of the software product.

E.1.2.3 Configuration/Change Management Repositories

This section will describe the use and maintenance of the configuration repositories, including types (i.e., physical or electronic), control mechanisms, and retention policies and procedures. The approach for managing the Code Library defined in Section 5.17, Deliverables 4.2, 6.6 & 8.3 should be included.

E.1.2.4 Configuration Audits and Reviews

This section will describe any audits or reviews of the configuration management process or library that will be conducted during the Project (i.e., audit of product baseline, audit of configuration library, and review of plan).

E.1.2.5 Other Configuration Management Processes

The Contractor must explain its approach to developing or using a COTS correspondence management system to manage official correspondence between the Contractor and the DHSS Project Management team. The system should be web-based and conform to the systems architecture or State standards. All written and official electronic correspondence between the State and the DHSS must be logged, archived, and maintained by the Contractor for 7 years beyond the term of the Contract and any amendment(s) of the Contract. The Contractor must provide DHSS with electronic access to this correspondence, including access to images of all written correspondence.

E.1.3 Deliverable – 1.4 Software Development Methodology

Overview: The Contractor will describe its established software development methodology, including approach, tools, hardware and software environment, methods, processes, standards, evaluation criteria, and terminology. The Contractor is required to describe and use an established methodology and tool set that has been applied on a project of similar size and complexity. The system development methodology shall address all components of the system, including web applications. At a minimum, the deliverable shall include:

E.1.3.1 Software Development Overview

This section will provide an overview of software development activities that will be performed by the Contractor and the environment in which this work will be completed. This will include issues such as security, privacy, standards, and interdependencies in hardware and software development.

E.1.3.2 Software Development Methodology

This section will describe the Contractor's methods and process for using a systematic, documented approach for all software development activities. This Section will address the following elements:

1. Software Development Methods – The Contractor shall describe the software development methods that will be used in the Project, including the use of iterative development if appropriate. This will include descriptions of manual and automated tools and procedures that will be used in support of these methods.
2. Standards for Software Products – The Contractor shall describe the standards to be followed for representing requirements, design, code, test cases, test procedures, and test results. Standards for code will be provided for each programming language used and will include at a minimum:
    a. Standards for format.
    b. Standards for header and other comments.
    c. Naming conventions for variables, parameters, procedures, etc.
    d. Restrictions, if any, on the use of programming language constructs or features and the complexity of code aggregates.
3. Critical Requirements – The Contractor shall describe the approach to be followed for handling requirements that are designated as critical to the success of the Project.
4. Hardware Resource Utilization – The Contractor shall describe the approach that will be followed for allocating computer hardware resources and monitoring their utilization.
5. Recording Key Decisions – The Contractor shall describe the method to be followed for recording issues and rationale that will be useful to DHSS for key decisions made during development activities.

E.1.3.3 Detailed Requirements Analysis and Design Methodology

This section will describe the Contractor's methodology and approach to defining the detailed requirements analysis, design and development activities, and deliverable review for the Replacement DMES. It will address the following elements:

1. The approach and methodology to construction and quality assurance activities to ensure adherence to design requirements.
2. The development approach, including phased development if applicable.
3. The change management and requirements management control processes.

E.1.4 Deliverable – 1.5 Project Repository

Overview: The Contractor is required to provide and use an electronic project repository that serves as a foundation for defining, managing, and monitoring the Project and provides a means to retain and track critical project information. The repository will include both current and historical versions of the Project Plan and all SOW Deliverable documents. The repository will be maintained throughout the life of the Contract, including during system operations and maintenance. At a minimum, the Deliverable shall include:

E.1.4.1 Overview, Organization, and Content

This section will provide an overview of the Project Repository, including the technology or tools employed by the repository, and the organization and location of the repository. It will also provide a list of the items to be maintained in the repository.

1. Overview of the Project Repository – The Contractor shall describe the technology or tools employed by the Repository and its utilization in controlling all Project Deliverables.
2. Organization And Location Of The Project Repository – The Contractor shall describe how the Project Repository will be organized, identification of the location of the repository and how it will be made accessible through DHSS's or the State's network, and a description of the naming/numbering conventions to be used for items in the repository.
3. Project Repository Contents – The Contractor shall describe the list of the documents and other items to be maintained in the Project Repository. Items will be listed by name/title/number with a link to the folder where the item can be found.

E.1.4.2 Repository Management

This section will describe how the documents and items in the Project Repository will be controlled, including document management procedures and version control.

1. Document Management – The Contractor shall describe the process to add new items and updated items to the Project Repository. The Section will also describe the management of historical records, and retention period(s) and procedures for archiving documents.
2. Version Control – The Contractor shall describe procedures for managing version control on all items added to the repository.

E.1.4.3 Access to the Project Repository

This section will identify who has access to the repository, how to access the information, and what security measures are in place to ensure that only authorized personnel can access the repository.

1. Personnel – The Contractor shall describe how access will be managed for specific Contractor, DHSS, and QA Contractor staff for documents and artifacts in the Project Repository, the level of access, and any restrictions on access to specific documents.
2. Security – The Contractor shall describe the security measures that will be in place to ensure that only authorized personnel have access to the Project Repository.

E.1.4.4 Roles and Responsibilities

This section will describe the roles and responsibilities of the Contractor and DHSS for implementation and maintenance of the Project Repository. This section will include:

1. Contractor Roles and Responsibilities – The Contractor shall describe its responsibilities for implementation and maintenance of the Project Repository and identification of the members of the Contractor's team who will be assigned to those responsibilities.
2. DHSS Access – The Contractor shall describe the process to determine and provide authorization and access to DHSS staff that will have rights to use to the Repository.
3. QA Contractor Access – The Contractor shall describe the process to determine and provide authorization and access to QA Contractor staff that will have rights to use to the Repository.
4. Other roles and responsibilities, if required.

E.1.5 Deliverable – 1.6 Project Status Reporting

Overview: The Contractor must prepare written status reports in formats approved by the DHSS and attend status meetings on a schedule approved by the DHSS. The Contractor will begin to prepare status reporting during the Planning Phase continuing on through the SDLC. The status report will be delivered to DHSS by noon prior to the next day's meeting.

The Contractor will be responsible for consolidating reports required for the management of projects by either integrated project management tools or COTS products when necessary.

E.1.5.1 Content

At a minimum, the report will include accomplishments, critical issues, personnel utilized, and items planned for the next reporting period. It will also summarize schedule performance and budget performance to compare actual project performance with plan(s). The Contractor will include the following:

1. Activities completed in the preceding period including minutes from the prior meeting.
2. Activities planned for the next period.
3. A report on issues that need to be resolved.
4. A report on the status of risks, with special emphasis on change in risks, risk triggers, or the occurrence of risk items.
5. A report on the status of each task in the WBS that is in progress or overdue.
6. A schedule variance report showing the earned value of the work completed, and the planned value of the work completed. The variances shall be calculated individually for each project phase and for the project in total and will be accompanied by a trend analysis.

7. Weekly, Monthly, and Quarterly Status reports summarizing data from the agreed upon interval (e.g., weekly) reports, including financial information related to expenses and billings.
8. Executive summaries for presentation to management and oversight bodies.

E.1.6 Deliverable – 1.7 Security Policies and Procedures

Overview: The Contractor shall have in place 90 days prior to "Go-Live" the following policies, procedures and identified security related documentation that must be filed with IRM/DTI. These policies, procedures and documentation must be in place and adhered to for the life of the Contract. At a minimum, the Deliverable shall include:

E.1.6.1 Workforce Security

Supervision

The Contractor will describe its Supervision policies and procedures for employees accessing or working in facilities and/or areas associated with this Project.

Clearance Procedures

The Contractor shall describe its Clearance procedures for employees accessing or working with this Project.

E.1.6.2 Security Incident Reporting and Response

The Contractor shall describe its procedures for reporting any security incidents in accordance with their policy, while under Contract with DHSS.

E.1.6.3 Security Awareness

Contractor shall describe the approach to security awareness and security training for all members of its workforce.

E.1.7 Deliverable 1.8 & 6.7 – Business Continuity Plan

Overview: The Business Continuity (BCP) focuses on the assurance of continued business operations for the DMES in the event of a disaster or other unforeseen disruptions. This deliverable is the first of a two part deliverable which addresses the BCP to protect the development, test, training, and production environments during the DDI phase of the project (Deliverable 1.8). Deliverable 6.7, Part 2, is the plan for the operations phase of the project.

The Contractor shall deliver a preliminary Business Continuity Plan (BCP) during the Planning Phase, and shall continue to update and test this plan through the Operations Phase as scheduled and agreed to by the State.

At a minimum, the Deliverable shall include:

E.1.7.1 Backup and Recovery Approach

This section will present the Contractor's approach for protecting the system against hardware and software failures and other emergencies that could interrupt system operations and services.

E.1.7.2 Scope

This section will address the scope of the plan including identification of:

1. All business functions covered by the BCP.
2. All business units affected by the BCP.
3. Core business processes involved in the DMES.
4. All people involved in the BCP and their roles, as well as the key people involved in the business processes noted above.
5. The plan shall establish the methodology for planning replacement of personnel to include:
    a. A plan for the allocation of additional resources in the event of the Vendor's inability to meet performance standards.
    b. A plan for the replacement/addition of personnel with specific qualifications.
    c. An indication of the time frames necessary for replacement.
    d. A report on the vendor's capability of providing replacements/additions with comparable experience.
    e. A description of the methods for ensuring timely productivity from replacements/additions.
6. All technology infrastructure involved in the DMES.

E.1.7.3 Risk Analysis and Action

This section will explain the risks that could affect business continuity. For each core business process noted in Section E.1.7.2, identify:

1. Potential system failures for the process.
2. Impacts analysis for potential failures.
3. Definition of minimum acceptable levels of service.
4. Documented contingency plans.
5. Definition of the triggers for activating the contingency plans.

E.1.7.4 Backup Plan

This section will explain the Contractor's approach for establishing a methodology for backup processing capability at a remote site from the Contractor's primary site, such that normal payment processing, as well as other system and State services deemed necessary by the State, can continue in the event of a disaster or major hardware problem at the primary site. The plan will include the following elements:

1. Weekly back-up.
2. Daily back-up.
3. Back-up storage at a secure offsite location.

4. Storage media – offsite storage of backup operating instructions, procedures, reference files, systems documentation, programs, procedures, and operational files; and procedures must be specified for updating offsite materials.
5. Off-site storage facility security, including protections against unauthorized access or disclosure of information, fire, sabotage and environmental considerations using best practices as developed by the National Institute of Standards and Technology (NIST).
6. Responsibilities of Contractor staff.

The Contractor will perform backup demonstrations at no additional cost to the State. Failure to successfully demonstrate the procedures may be considered grounds for termination of this Contract. The State reserves the right to waive part or all of the demonstrations. In the event the Contractor's test is deemed by the State to be unsuccessful, the Contractor will continue to perform the test until satisfactory, at no additional cost. The BCP Plan must be available and available at the DHSS site.

E.1.7.5 Disaster Recovery Plan

The new DMES shall be protected against hardware and software failures, human error, natural disasters, and other emergencies, which could interrupt services. The Disaster Recovery Plan (DRP) focuses on securing the data and software used by the DMES. The Contractor must secure the data and software based on a DMMA-approved DRP plan.

As part of the overall Business Continuity Plan, the Contractor will deliver a Disaster Recovery Plan (DRP) 90 calendar days before system implementation and will demonstrate the remote site functionality of each component of the plan prior to “Go-Live.” The Contractor is expected to maintain the plan throughout the life of the Contract. The plan must address recovery of business functions, business units, business processes, human resources, and the technology infrastructure.

The Contractor shall continually review the Disaster Recovery Plan and make necessary updates to the plan at least annually to ensure the plan always contains accurate and up-to-date information. Copies of each update will be provided to DHSS as they become available annually. Additionally, the Contractor will participate in the disaster recovery tests, as directed by DHSS.

This section will address disaster recovery documentation and procedures that will include both DHSS and Contractor responsibilities. The plan will address the following requirements:

1. Appropriate checkpoint/restart capabilities.
2. Address network backup for voice and data telecommunications circuits and Contractor owned voice and data telecommunications equipment.
3. Address backup procedures and support to accommodate the loss of online communication in excess of 2 business days between the Contractor's processing site and the State.
4. Continued processing of all business transactions assuming loss of the primary processing site, including provision for interim support for the online component of the DMES.
5. Description of offsite media storage facility for client/server and mainframe backup media, data file, software and back-up retention.
6. Description of the hardware backup procedures for the main processors.

7. Location of procedure manuals and other documentation for the DMES operations.
8. Procedure for updating offsite materials (acquisition and maintenance of the offsite storage facility shall be the responsibility of the Contractor).
9. Recovery procedures for loss of manual files and hardcopy documents.
10. Conduct Disaster Recovery tests every six months and review the results of this process with IRM and DTI to ensure that it is sufficient.
11. Ensure that each aspect of the Plan satisfies all requirements for federal certification and normal Medicaid Enterprise day-to-day activities and services can be resumed within 5 working days of the inoperable condition at the primary site.
12. Use of Uninterruptible Power Source (UPS) at both the primary and alternate sites with the capacity to support the system and its components.
13. Document batch processes; and have a plan that details how each batch process is supported and carried out with regard to sender, receiver, location, process, date and databases updated to achieve a full restore.
14. Conduct an annual disaster recovery demonstration for all critical system components at a remote site once during the first year of the Contract period and annually thereafter, in accordance with the 45CFR 95.621(f). All administrative, manual, input, processing, and output procedures functions, will be demonstrated including: the processing of one daily and one weekly payment processing cycle, at a minimum; a test of all online transactions; a test of query and reporting capability; and verification of the results against the corresponding procedures and production runs conducted at the primary site.

E.1.8 Deliverable 2.1 – Detailed Requirements Specification

Overview: The RFP review and the requirements research and discovery activities conducted by the Contractor culminate in the development of Requirements Specification Documents (RSDs) for each module and system component of the DMES. Requirement Specification Documents must include system functional, and non-functional, requirements (e.g., quality attributes, legal and regulatory requirements, standards, performance requirements, and design constraints).

The Contractor will must also describe its approach to developing a Requirements Traceability Matrix (RTM), to track all requirements through each stage of the development life cycle from requirement specification through production deployment. The Contractor must also describe how the RTM will be made accessible to both DHSS and the QA/IV&V Contractor.

E.1.8.1 Requirements Specification Document

At a minimum, the Contractor must construct a Requirements Specification Document that is capable of the following:

1. Include the methodology to be used for developing requirements.
2. Include the requirement exactly as it exists in this RFP, including the reference number.
3. Identify how and where the requirements are met in the Solution.
4. Validate the proposed solution meets Medicaid Information Technology Architecture (MITA) requirements.

5. Include a crosswalk or map of each requirement.
6. Identifies and verifies of all internal and external interfaces.
7. Includes a means of measuring that the requirement has been satisfied.

The construct of the RSD document must include at a minimum:

1. Introduction.
2. Overview of all processes.
3. Overview and purpose of all interfaces.
4. Discussion of the design implications for each major element of the project.
5. System designs or modifications necessary to complete the project.
6. General report definitions.
7. General screen definitions.
8. System behavior model (user interfaces-free form).
9. High-level flowcharts.

E.1.9 Deliverable 3.1, 4.6, 6.8 & 8.6 - Detailed System Design Versions 1, 2, 3 & 4

Overview: This Deliverable captures the requirements for system and system component service delivery and the methods to be used to ensure that each technical functional requirement has been addressed and performs as designed. Requirements pertaining to internal, external, and human interfaces and programmable integration points are presented. The Detail System Design (DSD) documentation will have 3 separate versions as deliverables before becoming the 4th and final version System Documentation (Sysdoc) in Task 8, Implementation.Task 3, Design, Task 4 Development, and Task 6, Acceptance Testing, must complete as updates to the prior version before the final update in Task 8, Implementation.

E.1.9.1 Detailed System Design Document

The Detailed System Design (DSD) document shall encapsulate, at a minimum, the following:

1. A table of contents and list of tables and figures.
2. A systems standards manual, listing all standards, practices, and conventions, such as language, special software, identification of all development, test, training and production libraries, and qualitative aspects of data modeling and design.
3. A general narrative of the entire system and the flow of data through modules and system components including all major inputs, processes, and outputs.
4. General and detailed module and system component narratives describing the purpose, use and general business description of each function, process, and feature.
5. Data model, including data elements to be used in each physical schema and function, their derivation, source, validation, definition, residence, and use.
6. A security design description for each business area that defines access control, including specifying roles, role locations, and a matrix of roles by inputs/outputs.
7. A listing and brief description of each file and report to be produced by module or system component.

8. The name and description of each screen/window, a view of each window layout and a detailed specification table explaining each data element contained within Interfaces and data acquisition.
9. Recommended cycle times, report frequencies, database update schedules.
10. A description of each interface, inputs, outputs file layout and corresponding specification table.
1. A matrix or exhibit that assists in defining requirements.
11. Information technology requirement.
12. Meeting notes from all requirements analysis meetings.
13. Open items.
14. Other issues or constraints affecting the DMES implementation and recommended DHSS or Contractor action.

E.1.10 Deliverables 3.2, 4.7, & 8.1 – Implementation Plan, Versions 1, 2, & 3

Overview: This Deliverable describes the Implementation Strategy and outlines how the objectives of the strategy will be achieved. There will be three versions of the Implementation Plan, one each as a Deliverable for Task 3, Design, Task 4, Development, and Task 8, Implementation. Versions 2 and 3 shall be updates to the prior version. At a minimum, the Deliverable shall include:

E.1.10.1 Installation Overview

This section shall be divided into the following paragraphs to provide an overview of the installation process.

1. Description – Description of the installation process to provide a frame of reference for the remainder of the document. A list of sites for software installation, the schedule dates, and the method of installation shall be included.
2. Contact point – The organizational name and telephone number of a point of contact for questions relating to this installation.
3. Support materials – Description of the type, source, and quantity of support materials needed for the installation. Included shall be items such as magnetic tapes, disk packs, computer printer paper, and special forms.
4. Tasks – Description of each task involved in the software installation.
5. Personnel – Description of the number, type, and skill level of the Contractor's personnel needed during the installation period.
6. Security and privacy – Description of the security and privacy considerations associated with the system.

E.1.10.2 Site-specific Information for Data Center Operations Staff

This section provides information for installation of the software in the computer center(s) or other centralized or networked software locations.

1. Schedule – Description of the schedule of tasks to be accomplished during installation. It shall depict the tasks in chronological order with beginning and ending dates of each task and supporting narrative as necessary.
2. Software inventory – Description of the process to provide an inventory of the software needed to support the installation.
3. Installation team – Description of the composition of the installation team. Each team member's tasks shall be defined.
4. Installation procedures – The step-by-step procedures for accomplishing the installation. The procedures shall include the following, as applicable:
    a. Installing the software.
    b. Verify the software is fully functional and operating as designed once installed.
    c. Initializing databases and other software with site-specific data.
    d. Conversion from the legacy system, possibly involving running in parallel.
    e. Dry run of the procedures in operator and user manuals.
    f. Data update procedures – Description of the data update procedures to be followed during the installation period.

E.1.10.3 Implementation Issues

The Contractor shall describe the process to document issues, planned resolutions, and solutions including the updating the BCP and Disaster Recovery Plan for identifying, communicating, resolving risks, and maintaining the current production capability, if the implementation is delayed.

E.1.10.4 Transition Planning

The Contractor will explain its approach for developing a co-working relationship with DHSS staff, technical preparation and change over activities in anticipation of transitioning to system support. Transition planning must address at a minimum, the following:

1. Development of an implementation activities checklist.
2. Identify cutover procedures and dates for submittal of claim records on electronic media claims and hard copy.
3. Documented resolution of inventory issues (e.g., suspense, claim records on hand, provider enrollments) and associated dates.
4. Documented plans for installation of lines and workstations.
5. Specify methodology for handling adjustments to legacy processed claim records.
6. Identify the process to accommodate provider updates, beneficiary data changes, reference changes, and prior authorizations; after final conversion but before implementation.

E.1.11 Deliverable 3.3 – System Architecture and Design Document

Overview: The delivered system will be an integrated system of COTS products to the maximum extent possible. The DMES will subsume the functionality of legacy systems and will interface with external systems via the DMES interfaces specified in the Interface Design

Description (IDD) and Integration Specification document. The System Architecture and Design document (SADD) is the overall document for the DMES DDI project and provides an understanding of the end-state architecture and design acknowledging that the system is being developed in increments. The document provides a description of the system's modular component design and Service Oriented Architecture (SOA). The SADD must have both high-level and detailed specifications. It must include business process models and data models of the entire system and all system and operations functions, showing inputs, processes, programs, interfaces, program interrelationships, and outputs. It must also include a cross-reference to the corresponding Sections of Part 11 of the State Medicaid Manual. The Deliverable will follow the Contractor's proposed and approved development methodology by DHSS.

E.1.11.1 General System Architecture

This section will define the high-level architecture and design of the DMES, including the following items:

1. A narrative describing the entire system.
2. A description and flow charts showing the flow of major processes in the DMES.
3. A description of al operating environments.
4. Function documentation, including narratives for each functional area and feature of the function, job streams, input and output definitions, and control reports.
5. Hardware requirements, including configuration, usage estimates, sizing, bandwidth, and response time.
6. Software requirements, including number of users, concurrent users, and location of users; number and type of licenses.
7. Development tools, including required software, number of users and concurrent users, number and type of licenses.
8. Communication tools, including required hardware and software, number and type of licenses required and total number of users.
9. System configuration diagram showing all hardware and software.
10. Software specifications that define software components: 1) to be developed specifically for Delaware, 2) that will use software proprietary to the Contractor, and 3) that will use Commercial-Off-the Shelf (COTS) software.

E.1.11.2 Detail System Architecture and Design

This section will provide the detail system architecture and design specifications for the DMES, including:

1. Detail program specifications:
    a. Program narratives including process specifications, purpose, and relationships between the programs and modules.
    b. A list of input and output files and reports, including retention.
    c. File/database layouts, database names, and dispositions.
    d. Detailed program logic descriptions.

e. Listings of edits and audits applied to each input item.

f. Detailed pricing logic for all claims processed by the system.

2. Data element dictionary that includes:

   a. A unique data element number and standard data element name.

   b. A narrative description and definition of the data element.

   c. A table of values for each data element.

   d. The source of each data element.

   e. Descriptions of naming conventions used to create data element names and a list of data names used to describe the data element.

   f. A cross-reference to the corresponding State Medicaid Manual.

   g. A list of programs using each data element, describing the use of input, internal, or output.

   h. A list of files containing the data element.

3. Table descriptions, including:

   a. A description of all tables used in the system.

   b. A listing of table-driven or key elements, their values, a written description of the element, and to which subsystems they apply.

   c. Cross-reference listings or matrices of related elements or values, showing allowable relationships or exclusions (e.g., Provider Type/Provider Specialty cross-reference).

   d. A business rules repository.

   e. A table of contents, by function, table and element.

E.1.11.3 Interface Design Description and Integration Specification Document

The section serves to facilitate and to communicate and control interface design decisions. The IDD is used to describe interface characteristics selected to meet Interface Requirements Specification and interface characteristics of one or more systems, subsystems, Hardware Configuration Items (HWCIs), Computer Software Configuration Items (CSCIs), manual operations, or other system components. It also describes: the functionality between systems and system components, how they are linked to one another as well as providing an abbreviated view of full user interface design where applicable. The Contractor shall include the following in the document construct:

1. Identification – The Contractor shall provide a full identification of the systems, interfacing entities, and interfaces to which this document applies, including: identification numbers, titles, abbreviations, version numbers, and release numbers as applicable.

2. System Overview – The Contractor shall briefly describe the purpose of the systems and software to which this document applies. It shall describe the general nature of the system and software; summarize the history of system development, operation, and maintenance; identify the project sponsor, acquirer, user, developer, and support agencies; identify current and planned operating sites; and list other relevant documents as applicable.

3. Document Overview – The Contractor will summarize the documents purpose and contents and will describe any security or privacy considerations associated with its use.
4. Interface Design – This section shall describe the interface characteristics of one or more systems, subsystems, configuration items, manual operations, or other system components. If part or all of the design depends upon system states or modes, this dependency must be indicated.
5. Interface Identification and Diagrams – The Contractor will describe the identifier assigned to each interface and shall identify the interfacing entities (e.g., systems, system components, configuration items, users) by name, number, version, and documentation references, as applicable. A systems configuration diagram showing all DME interfaces is also required. Entities with fixed interface characteristics must be identified (impose interface requirements on the interfacing entities). One or more interface diagrams shall be provided, as appropriate, to depict the interfaces. Interfacing entities that need mention but are not part of this document should be noted as to it future possible engagement potential.
6. Interface design descriptions should include the following:
    a. Interface assigned priority.
    b. Type of interface (such as real-time data transfer, storage-and-retrieval of data, etc.) to be implemented.
    c. Characteristics of individual data elements and data element assemblies (records, messages, files, arrays, displays, reports) that the interfacing entity will provide, store, send, access, receive, to include:
        1) Names/identifiers.
        2) Data type (alphanumeric, integer, etc.).
        3) Size and format (such as length and punctuation of a character string).
        4) Units of measurement (such as meters, dollars, nanoseconds).
        5) Range or enumeration of possible values (such as 0-99).
        6) Accuracy (how correct) and precision (number of significant digits).
        7) Priority, timing, frequency, volume, sequencing, and other constraints, such as whether the data element may be updated and whether business rules apply.
        8) Security and privacy constraints.
        9) Sources (setting/sending entities) and recipients (using/receiving entities).
    d. Characteristics of communication methods and protocols that the interfacing entity will use for the interface including:
        1) Project-unique identifier.
        2) Communication links/bands/frequencies/media and their characteristics.
        3) Message formatting.
        4) Flow control (such as sequence numbering and buffer allocation).
        5) Data transfer rate, whether periodic or irregular, and interval between transfers.
        6) Routing, addressing, and naming conventions.

7) Transmission services, including priority and grade.

8) Safety/security/privacy considerations, such as encryption, user authentication, compartmentalization, and auditing.

e. Characteristics of protocols the interfacing entity will use for the interface, such as:

1) Project-unique identifier(s).

2) Priority/layer of the protocol.

3) Packeting, including fragmentation and reassembly, routing, and addressing.

4) Legality checks, error control, and recovery procedures.

5) Synchronization, including connection establishment, maintenance, termination.

6) Status, identification, and any other reporting features.

f. Other characteristics, such as physical compatibility of the interfacing entity (dimensions, tolerances, loads, plug compatibility, etc.

g. Traceability to requirements addressed by the interfaces.

E.1.11.4 Interface Control Document

This section describes how to access the functions and services provided by the DMES via the interface. The Interface Control Document (ICD) is about the interfaces themselves, and not the characteristics of the systems which use it to connect.

E.1.11.4.1 Scope

The Contractor shall develop an Interface Control Document (ICD) to track the necessary information required to effectively define the DMES's interface as well as any rules for communicating with them in order to give the development team guidance on architecture of the system to be developed. The ICD must clearly communicate all possible inputs and outputs from the DMES for all potential actions whether they are internal to the system or transparent to system users. The ICD shall be created during the Design Task of the project. Its intended audience is the project manager, project team, development team, and stakeholders interested in interfacing with the system. The ICD helps ensure compatibility between modules and system components.

E.1.11.4.2 Interface Requirements

This section will describe the intended functionality and purpose of the interface together with any design constraints as follows:

1. Identification of the interfacing module or system component.
2. The reason for the interface's existence including the user requirement that is satisfied.
3. A description of what the interface does.
4. Specification of the information to be exchanged (e.g., data type, size, format, measures).
5. Timing and sequencing constraints.
6. Capacity and performance requirements.
7. Requirements for communications protocol standards compliance.

8. Identification of any safety requirements discovered in an Interface.

E.1.11.4.3 Interface Design

This section shall describe based on design, how the interface will be implemented such as:

1. Interface Type: task to task, external, user, serial, parallel.
2. Protocol: A description of the communications protocol. Protocol descriptions may include:
   a. Message format and description including user error messages, user information messages, and inter-process messages.
   b. Message component names.
   c. Message initiation.
   d. The processing of message interruptions. Fragmentation and reassembly of messages.
   e. Error detection, control, and recovery procedures.
   f. Synchronization, including connection establishment, maintenance, termination and timing and sequencing.
   g. Flow control, including sequence numbering, window size and buffer allocation.
   h. Data transfer rate.
   i. Transmission services including priority and grade.
   j. Security including encryption, user authentication and auditing.
   k. Error codes.

E.1.12 Deliverable – 3.4 Architectural Review Board Requirements

Overview: The DHSS, Delaware Department of Technology and Information (DTI) Architecture Review Board (ARB) requires that the following documents be completed and submitted to DTI for review and approval. The policy and templates for the deliverables can be found at the DTI website (http://dti.delaware.gov/information/standards-policies.shtml).

DTI is aware that for proprietary SaaS (Software as a Service) and COTS solutions, the vendor may not share all of this information. If the information is not provided, the vendor should submit the proper waiver requests to DTI through DMMA.

The Contractor must have submitted and DHSS approved the following deliverable documents in order to complete the Design Phase:

E.1.12.1 Data Model Standards

The Contractor must demonstrate that all databases have conceptual and physical data models and must be completed as part of the DSD. According to the State of Delaware Data Modeling Standard, http://dti.delaware.gov/pdfs/pp/DataModelingStandard.pdf, the acceptable data modeling tools are Sybase Power Designer, CA Erwin, and IBM Rational Data Architect.

The data model shall also include pertinent information about the data including (but not limited to), definitions, and sharing rules. The physical data model should also include a data matrix when the data is coming from another source.

E.1.12.2 Network Diagram Standards

The Contractor shall present a full network architecture diagram showing the entire DMES including servers, server type, interfaces, network connections, and physical location. **Note:** As part of Contract negotiations, the selected vendor will work with IRM to include a preliminary draft diagram for each proposed environment until architecture diagrams can be finalized, submitted to and approved by the ARB during the design task. The draft diagrams will be included in the final Contract. This will also be made part of a project business case that must be in "Recommended" status prior to Contract signature. The project business case is a State responsibility.

E.1.12.3 Process Flow Modeling Standards

The Contractor must create process flow diagrams that provide an overview of the workflow processes starting with the end users. Many applications have multiple workflows with decision points and multiple diagrams to describe. This should include what type of data is being sent at each point.

E.1.12.4 Software Disclosure List

The Contractor must provide a list of all software to be used in the Delaware Medicaid Enterprise System. The Contractor should follow the DTI template for software listing which includes:

1. Software product name.
2. Software product version.
3. Vendor of software product.
4. Software required for development.
5. Software required for support.

E.1.12.5 Physical Environment Standard

The Contractor will create physical environment diagrams depicting what physical hardware, what operating system, and what applications are being used at each point. If DMZ's are shown in the network diagram, then firewall devices that define these DMZ's are assumed and do not have to be shown.

E.1.13 Deliverable 3.5 – Test Management Plan

Overview: The Contractor must develop a Test Management Plan and schedule for each phase of testing: Unit, System/Module, Integration, Rules and regression (for system components requiring customization). The Test Management Plan must describe the methodology, processes and tools proposed for successful testing. The Test Management Plan must include:

E.1.13.1 Approach to Testing

1. Testing Philosophy and Approach:
    a. Test Standards.
    b. Steps in the testing process.

c. Verification Approach: how the development of the test scenarios ensures that all modules, rules, and functions of the DMES are evaluated and accepted.
d. Approach to Non-Testable Requirements.
e. Contingency plans for risk mitigation and delays.

2. Test Phases:
   a. Unit, System/Module, Rules, Integration/Interface, Regression, Stress and Load.
   b. Relationship of test phases to each other.
   c. Test Techniques and Methods.
3. Test Environments and Tools:
   a. Configuration Management of Environment and Tools.
   b. Verification of Test Tools. (Do they work correctly themselves?)
   c. Workflow and Training requirements.
   d. Test Data, including use of de-identified test data.
4. Roles and Responsibilities:
   a. Contractor Staff.
   b. DHSS Staff.
   c. QA Contractor Staff.
   d. External Organizations:
      1) Sponsor.
      2) User.
      3) Interfacing Organizations.
   e. Required Skills for Roles.
5. Test Documentation:
   a. Documentation Standards.
   b. Documentation Templates.
   c. Content and Format.
      1) For each test document: plans, cases, procedures.
6. Test Schedule and Work Plan.
7. Test Metrics and Measurements:
   a. Tests Executed.
   b. Tests Passed.
   c. Tests Failed.
   d. Test Incidents (by criticality).
   e. Subsequent Defects.
   f. Subsequent Change Orders or Work Authorizations.

8. Test Pass/Fail Criteria.
9. Test Closure Criteria.

E.1.13.2 Testing Processes

1. Test Preparations.
   a. A description of test scenarios and expected test results.
   b. Plan to organize test results.
   c. A plan for system performance measuring and tuning, based on the results of load/stress testing.
   d. Plans for updating the RTM and DSDs.
2. Orientation and Kickoff.
3. Test Execution.
4. Test Monitoring.
   a. Test Tracking.
   b. Defect Identification (Severity) Process.
   c. Defect Resolution Process.
5. Test Status Meetings and Reporting.
6. Test Exit Meetings:
   a. Go/No-Go Decisions or Checkpoint Decisions.
   b. Closure Evaluation Criteria.
7. Test Closure and Wrap Up.
   a. Archiving, Lessons Learned.

E.1.14 Deliverable – 3.6 Network Upgrade Requirements

Overview: This Deliverable will detail the needed enhancements to the DHSS network and desktops in order to support the system performance and security requirements specified in Attachment. At a minimum, the deliverable shall include:

E.1.14.1 Network Requirements Specification

This section will define the network requirements for the Replacement MMIS, including:

1. Network Requirements for the DMES – This Contractor shall present the network configuration and identify the components needed to operate the DMES. The requirements shall include everything necessary to make the DMES accessible by all enterprise users – internal and external.
2. Telecommunications Requirements for the DMES – This Contractor will identify all telecommunication components required to meet the telephony and communication requirements of the DMES. The requirements shall include the specifications and quantity of the components.

E.1.14.2 Desktops

This section will identify DHSS desktops requiring upgrades or replacement.

E.1.15 Deliverable – 3.7 Data Conversion Strategy

Overview: The Contractor will describe its strategy for converting and validating the accuracy of all legacy MMIS data into the new DMES. The strategy shall also include how all interfaces will be achieved.

E.1.15.1 Approach to Developing the Conversion Strategy

The Contractor will describe the general approach that will be used to document and communicate the data conversion scope, objectives, approach, and requirements to complete the data conversion processes for the new DMES. The strategy must address all data conversion requirements, regardless of whether an automated or manual method is recommended. This section shall discuss and address the following:

1. Determine whether any portion of the conversion process shall be performed manually.
2. Determine whether legacy and new systems will be required to run in parallel during the conversion process.
3. Determine if the data function in the legacy system will be used in the same manner or used differently in the new DMES.
4. Determine the order that data will be processed in the two systems.
5. Volume considerations, such as the size of the database and the amount of data to be converted, the number of reads, and the time required for conversions.
6. User work and delivery schedules and time frame for reports.
7. Determine task dependencies.
8. Determine whether data availability and use shall be limited during the conversion process.
9. Determine the plan for handling obsolete or unused data that is not converted.
10. Determine the plan for cleansing data from the legacy to the new DMES.
11. Determine critical factors, assumptions, constraints, risks, and issues that could affect the conversion process.
12. Determine if a clear disposition path exists for every business object/data element.

E.1.15.2 Scope

The Contractor must provide a general description of the scope of the data conversion effort. Include discussion as to whether the conversion process will be implemented in phases. This Section shall address the following:

1. Conversion objectives, impact and resources.
2. Files/data that will be converted or linked to the new system as an interface.
3. Plans for normalization of data to be converted.

4. Evaluation of DHSS ad hoc databases that facilitate Medicaid processes and whether their data needs to be converted and incorporated into the DMES.
5. The processes that will be used to complete the conversion including verification procedures and acceptance responsibilities.
6. Conversion support requirements including use of the system, policy issues and hardware.
7. List of conversion tools.
8. Schedule for completing the conversion processes.
9. Conversion preparation task outline.
10. Plans for necessary manual conversion and data cleanup activities.
11. Approach to ensure the accuracy of the converted data.
12. Plans for ensuring that legacy MMIS data will be continually updated with changes from interfacing systems and new systems until all modules and system components of the new DMES have been implemented.

E.1.16 Deliverable – 4.1 Development Environment

Overview: This Deliverable will describe and establish the Development Environment. The Contractor will create a fully maintainable integrated environment to be used for customization and maintenance of the DMES without disruption of any other DHSS computing activities, fully managing code development and testing over the SDLC. The Contractor must provide for adequate ongoing licenses to maintain each environment. The programs in the Development Environment must mirror production, except for the change being tested and must allow DHSS to monitor the accuracy of the DMES. This includes: processing test claims, using test files, and to run “what-if” type scenarios.

E.1.16.1 Development Environment

This document shall inventory the hardware, software, network, communication, and data storage components necessary to support the construction of the new DMES. It shall also list configuration management (see Section 1.2, Deliverable 1.3 and repository (see Section 1.4, Deliverable 1.5) tools and contain a platform architecture schematic that illustrates the technology components of the DMES.

The Contractor shall document its technical design of the six primary isolated processing environments to be used for the development of the new DMES, including a description of the variances from one environment to another. The six processing environments shall include:

1. Integration – An environment for the configuration and integration of the Framework with the Components and to establish interfaces with external systems.
2. Test – An environment robust enough to support multiple test scenarios simultaneously. Test will actually be comprised of a number of isolated sub-environments including a parallel test environment for the testing of major modifications.
3. Staging – An intermediate platform used to move Components, Products, and services from the test environment to the Production environment as part a formal release management process.
4. Development – an environment to be used when changes occur to the DMES.

5. Production – The fully tested and integrated DMES accessible by users.
6. Training – A separate environment to be used to train users.

Additional staging areas may be proposed at the discretion of the Contractor. Bidder will address how each of these regions will be set up and utilized. Except for special purpose development environments, these regions will be maintained for the life of the system. Proposals must provide for adequate ongoing licenses, Central Processing Unit (CPU) & storage capacity to maintain each region.

E.1.17 Deliverable – 4.2, 6.6 & 8.3 – Code Library, Versions 1, 2 & 3

Overview: The Code Library consists of the program source code, databases, documentation, executable software, modules and services and associated job control language to build and operate the new DMES. Version 1 of the Code Library, Test Environment, is developed during Task 4, Development. Version 2, Acceptance Testing Environment, is developed during Task 6, Acceptance Testing, and Version 3, Production Environment, is developed during Task 8, Implementation. The Code Library shall be governed according to the Change Management Plan, Section 5.2, Deliverable 1.3. At a minimum, each version of the deliverable shall include:

E.1.17.1 Source Code Library Construction

Establish a Code Library for keeping all artifacts of the development task. The Code Library is the repository for the executable software, source files, and software support information, including the “as built” design description and the compilation, build, and modification procedures, for a software system. This document shall detail the structure and organization of the Code Library. Other than program source code, a large part of this library will hold associated documentation including the service registry. The foundation for developing this library will be the updated system, program, and operating procedures documentation developed in prior tasks.

E.1.17.2 Documentation Content

This Section will describe the documentation that will be included in the library, including:

1. System narratives and module narratives (including structure charts), identifying the processes associated with each, the purpose of the program or module, and interrelationships between the programs and modules.
2. Detailed program logic descriptions and edit logic, including, at a minimum, the sources of all input data, all editing criteria, all business rules, all decision points and associated criteria, interactions with other programs, and all outputs.
3. Layouts for all files and database tables to include, at a minimum, file/database table names and numbers; data element names, numbers, number of occurrences, length and type; record names, numbers, and length; and file maintenance data such as number of records during routine operations, required disk space, file retention, and back-up.
4. Detailed comprehensive data element dictionary (DED), including, at a minimum, data element names, numbers, descriptions, and definitions (including length and type); valid values with definitions; sources for all identified data elements; table listings for all table(s) elements; and lists from the DED in multiple sort formats; a cross-reference to the corresponding Part 11 of the State Medicaid Manual.

5. Process descriptions showing the flow of major processes and data within each and across system components and modules.
6. System component or module name and identification; identify each program, input, output, and file; job streams within system components and modules identifying programs, input and output, controls, job stream flow, JCL, operating procedures, and error and recovery procedures; identification and listing of all Contractor internal control reports, including completion and reconciliation reports.
7. Software Development documentation to include:
    a. Application and database design and architecture.
    b. Application start-up/shut-down procedures.
    c. Application backup, recovery and restart procedures.
    d. Database logical and physical organization and maintenance procedures.
    e. Application and system security features.
    f. Audit and testing procedures.
    g. System data input, error checking, error correction and data validation procedures.
    h. User help procedures and features.
    i. System troubleshooting and system tuning procedures and features.
    j. System administration functions such as code/business rule management.
    k. Setting and changing of system User ID and password.
    l. System interface processing (internal and external).
    m. Online and batch processing.
    n. Unique processing procedures.
    o. Report generation procedures.
    p. Job Scheduling and Cycles.
    q. Change Control Process.
    r. Configuration Management Process.
    s. Additional areas defined by DHSS.
8. A Service Registry which describes and publishes the offered functionality of reusable services and how and where they may be consumed.

E.1.18 Deliverable – 4.3 & 6.3 – Development Test Results

Overview: This Deliverable describes the content and repository for development test results, which includes unit, modular and system component, systems integration and stress testing. At a minimum, the deliverable shall include:

E.1.18.1 Overview

Unit testing, modular and system component testing and systems integration testing shall all take place during Task 4 Development. Results will be reported as part of Deliverable 4.3, Development Test. Stress testing shall take place during Task 4, Development and Task 6,

Acceptance Testing. Results will be reported as part of Deliverables 4.3 and 6.3, Development Test Results and Acceptance Test Results.

E.1.18.2 Overall Assessment of the Software Tested

This Section shall:

- Provide an overall assessment of the software as demonstrated by the test results in this report.
- Identify any remaining deficiencies, limitations, or constraints that were detected by the testing performed. Problem/change reports may be used to provide deficiency information.

For each remaining deficiency, limitation, or constraint, describe the impact on software and system performance, including identification of requirements not met. Also, the following must be addressed:

1. The impact on software and system design to correct it.
2. A recommended solution/approach for correcting it.

E.1.18.3 Impact of Test Environment

This section shall provide an assessment of the manner in which the test environment may be different from the operational environment and the effect of this difference on the test results. **Note:** The UAT environment must be the technical equivalent of the production environment to minimize issues with promoted code and/or database changes in production.

E.1.18.4 Recommended Improvements

This section shall provide any recommended improvements in the design, operation, or testing of the software tested. A discussion of each recommendation and its impact on the software may be provided.

E.1.18.5 Detailed Test Results

This section shall describe the detailed results for each test. It will include test number, summary of test results, problems encountered, identification of test procedure step(s) where problems occurred, reference to backup material as appropriate, deviations from test cases/procedures, and an assessment of the deviations' impact.

E.1.18.6 Test Log

This section shall present, possibly in a figure or appendix, a chronological record of the test events covered by this report. This test log shall include at a minimum:

1. The date(s), time(s), location(s), and tester(s) of the tests performed.
2. The hardware and software configurations used for each test.
3. A record of DHSS signoff on the completed and successful tests.

E.1.19 Deliverable 4.4 & 8.4 – User Manual, Versions 1 and 2

Overview: The Contractor must prepare user manuals and procedure manuals for their respective business and technical areas. The purpose of the User Manual is to provide a software user instruction on how to perform the work activities assigned to their job. All user documentation must be developed with the user in mind so that users that are not data processing professionals can easily understand how to operate the DMES and can learn to access and interpret online screens.

The structure and format of the documents must have prior approval by the DHSS and have a consistent appearance across all system components and modules that make up the DMES. The first draft of user documentation must occur during the development phase for use during the testing phase. Appropriate updates will occur during the implementation phases to include changes and corrections to procedures or processes that were identified during testing. As the manuals near or are in a final version state, they will be used as the basis for user acceptance testing and for training before the start of operations, unless otherwise specified by DHSS.

The Contractor will be responsible for the production and distribution of all user documentation updates in a timely manner. Version 1 of the User Manual will be developed during SOW Task 4, Development. Version 2 will be updated during Task 8, Implementation. At a minimum, the Deliverable shall include:

E.1.19.1 General Requirements for User Manual

The User Manual shall give a software user step-by-step instruction for accomplishing tasks and work processes, creating reports, fixing errors and trouble shooting.

User documentation must adhere to the following standards:

1. Be available online via the DMES and inquiry functions must be presented separately from updating instructions.
2. User manuals must be written in a procedural, step-by-step format.
3. All functions and supporting materials for file maintenance (for example, coding values for fields) must be consolidated by module and by file within the business functional area.
4. Definitions of codes used in various sections must be consistent.
5. Mnemonics used must be identified and consistent with screens, reports, and the data dictionary.
6. Abbreviations must be consistent.
7. Field names for the same fields on different records must be consistent.

E.1.19.2 User Manual Contents

The user manual must include at a minimum:

1. User manuals must contain a table of contents and indices.
2. Descriptions of online error messages for all fields incurring edits must be presented with the corresponding resolution of the edit.
3. Tables of valid values for data fields (for example, provider types and claims types), including codes and descriptions in English, presented on screens and reports.

4. Illustrations of screens used in the system component or module, with all data elements on the screens identified by number; and all calculated or generated fields on the screens described clearly.
5. Instructions for entering online updates must clearly specify the screen to be used.
6. Instructions for requesting reports or other outputs with examples of input documents and/or screens.
7. Instructions for file maintenance, with descriptions of code values and data element numbers for reference to the data dictionary.
8. Each process and procedure shall identify the user, their location within the organization and the purpose (outcome) of the process or procedure.
9. Report descriptions for reports generated within the system to include:
    a. A narrative description of each report.
    b. The purpose of the report.
    c. Definition of all fields in reports, including detailed explanations of calculations used to create all data and explanations of all subtotals and totals.
    d. Definitions of all user-defined report-specific code descriptions and a copy of representative pages of each report.
    e. Instructions for requesting reports or other outputs must be presented with examples of input documents and/or screens.
    f. Provide and maintain a detailed user manual for the ad hoc reporting capability with instruction on how to use the online request function, and should include examples of the types of reports that can be generated.

E.1.20 Deliverable 4.5 & 8.5 – Operating Procedures, Versions 1 & 2

Overview: This Deliverable provides operating procedures to clearly document the system. The first version of this Deliverable will be developed during Task 4, Development. Version 1 will be updated and finalized during Task 8, Implementation, resulting in the Version 2 Deliverable. At a minimum, the Deliverable shall include:

E.1.20.1 General Requirements for Operating Procedures

The purpose of the Operation Procedures document is to assist programmers and other technical staff in operation and maintenance of the system. These procedures help define and provide understanding of system operations and performance. Operating procedures will:

1. Provide operations technical staff the knowledge to efficiently operate and maintain the system.
2. Be maintained online via the DMES.
3. Be revised with any changes resulting from acceptance testing, training, or changes in procedures during on-going operations.

E.1.20.2 Contents of Operating Procedures

The Operations Procedures will address all facets of the technical operation of the system including the following topics:

1. Application and database design and architecture.
2. Application structure and module/sub-module/program/subroutine relationships.
3. Application start-up/shut-down procedures.
4. Application backup, recovery and restart procedures.
5. Data dictionary structure and maintenance procedures.
6. Database logical and physical organization and maintenance procedures.
7. Application and system security features.
8. Audit and testing procedures.
9. System data input, error checking, error correction, and data validation procedures.
10. User help procedures and features.
11. System troubleshooting and system tuning procedures and features.
12. System administration functions, such as code management and copy file management.
13. Setting and changing system password and user ID.
14. System interface processing.
15. On-line and batch processing procedures.
16. Unique processing procedures.
17. Report generation procedures.
18. Menu structures, chaining, and system command mode operations.
19. Job scheduling.
20. Job cycles (daily, weekly, monthly, quarterly, annually, and special).

E.1.21 Deliverable 5.1 - Data Conversion Plan

Overview: This Deliverable shall elaborate on the Deliverable 3.7, Data Conversion Strategy as described in Section 1.15 and outline how the objectives of the strategy will be achieved. At a minimum, the Deliverable shall include:

E.1.21.1 Data Conversion Tasks

This Section will identify in detail the tasks and subtasks that must be performed in order to perform the necessary file conversions. Tasks should be listed in order of required occurrence. All task dependencies should be identified. This information may be depicted in the form of a work breakdown structure and appended to the plan. The conversion plan must include the following:

1. Perform an inventory of data to be converted and identify the data needed to populate the system so that the new DMES is fully functioning. Include data that is currently archived in the inventory. Establish the criteria for selecting archived data for conversion; identify archived data to be converted. Document physical location, media, and logistics involved in the conversion. Identify all data elements, files, and systems that will be converted including:
    a. Name.

b. Source form or record layout.
c. Storage medium.
d. Physical Location of storage medium.
e. Size.
f. Access method.
g. Security and privacy considerations.

2. Identify all control procedures and validation criteria used to ensure that all data intended for conversion has been converted.
3. Plan any interim file maintenance requirements.
4. Develop conversion programs including:
   a. Specifications.
   b. Program coding.
   c. Error/exception processes.
   d. Test plans.
   e. Hard-copy manual data entry screens, if necessary.
5. A discussion of the management of the conversion effort, including strategies for dealing with delays, contingencies, data reconciliation procedures, backup plan, backup personnel, process verification, and other issues impacting data conversion.
6. A detailed contingency plan to identify and mitigate risks that may be encountered during conversion.
7. Procedures for tracking and correcting conversion problems when encountered and for documenting any revised procedures in the conversion plan.
8. Specifications for manually converting data and capturing missing or unreliable data elements that cannot be converted.
9. Specifications for converting imaged documents.
10. Layouts of the reports produced as a result of conversion.
11. A definition of the metrics that will be generated by and used to measure the completeness of the conversion process.
12. Identification of default values, where necessary.
13. Steps for conversion.
14. Expected results.
15. Detailed mapping of the conversion elements (Source Fields to Target Fields) for each module and data files.

E.1.21.2 Resource Requirements

Identify the required personnel, equipment, and DHSS staffing resources needed to perform each identified task and subtask. Information on staffing resources may be depicted in the above referenced work breakdown structure appended to the plan.

The conversion plan must address the following resource requirements:

1. Identify necessary computer processing workloads.
2. Identify and plan manual support requirements.
3. Identify the Contractor and DHSS personnel needed to participate in the conversion of the data.
4. Plan any special training for conversion activities.

E.1.21.3 Schedule

Identify the time required to complete each task and subtask. This information may be depicted in the above referenced Work Breakdown Structure (WBS) and attended to the plan.

E.1.22 Deliverable 5.2 – Conversion Test Results

Overview: This deliverable includes execution of the data conversion and the testing performed to validate that data conversion programs are working correctly. The vendor shall be responsible for any data cleanup activities required and shall address any exceptions (data not successfully converted) resulting from the data conversion to the satisfaction of DHSS. At a minimum, conversion testing results reports will include the following:

E.1.22.1 Scope

This section will describe the scope of the testing the Contractor will perform for data conversion and interfaces, including:

1. Identify the system(s) and conversion software to which the report applies.
2. Provide system/software overview including purpose of the system(s), history, operation, sponsor and users.
3. Purpose of the test.

E.1.22.2 Overview of Test Results

This section will provide a narrative overview of the test results, including:

1. An overall assessment of the conversion software as demonstrated by test results.
2. Identification of any remaining deficiencies, limitations, or constraints that were detected by the testing performed. Problem/change reports may be used to provide deficiency information.
3. For each remaining deficiency, limitation, or constraint, a description of its impact on conversion software performance, the impact on software design to correct it, and a recommended solution for correcting it.
4. An assessment of how the test environment may be different from the operational environment and the effect of this on the test results.
5. Any recommended improvements in the design, operation, or testing of the conversion software tested.

E.1.22.3 Detailed Test Results

This section will present the detailed results of the conversion and interface testing with the goal of demonstrating that:

The converted data allows continued application of all edits, audits, service authorizations and pre-certifications including; units used, drug exception requests, rebates, and calculations, and to meet all other system processing requirements.

The conversion process allows DHSS and contractor staff the ability to view data transparently from previous periods in the legacy MMIS, including images of claims, provider, service authorizations and pre-certifications, and other documents imaged in the existing legacy system.

The converted data allows production of all reports required for system operation, policy decision-making and federal and DHSS reporting requirements.

The section will include the following:

1. Test data set.
2. The results of the testing in the format approved by DHSS.
3. Completion status of each test case associated with the test.
4. When results are not “as expected,” identification of the test case with an explanation of the problem(s) that occurred.
5. Identification of the test procedure step(s) in which problems occurred.
6. Documentation of the number of times the procedure or step was repeated in attempting to correct the problem(s) and the outcome of each attempt.
7. Identification of each test case in which deviations from test case/test procedures occurred, rationale for the deviation, and assessment of the impact on the validity of the testing.

E.1.22.4 Test Log

This section will provide a log of the testing that was done, including:

1. A chronological record of the testing covered by the report including dates, times and locations of tests performed.
2. Hardware and software configurations used for each test.
3. Dates and times of each test related activity including individuals who performed the activity.

E.1.22.5 Notes

This section will record any general information that aids in understanding the testing results including background information and a glossary of terms and acronyms.

E.1.23 Deliverable 6.1 – Test Environment

Overview: This Deliverable will describe and establish the test environment that was proposed in Section 5.16, Test Management Plan, Deliverable 4.5 and will be created by the Contractor. This Deliverable will be provided to DHSS before invoicing for Test Environment components. A separate test environment must be provided to avoid disruption of other production and implementation activities.

E.1.23.1 Test Environment

This section shall describe the test environment and related testing tools, including an automated system test tool. The test environment shall be a copy of the production environment including copies of all software, databases, tables and files loaded with de-identified test data. The test environment shall be available from the DHSS network and appropriately configured to adequately emulate Web real world system use. This section shall include an inventory of all software and data stores that will be duplicated in the test environment.

In order to adequately test system-to-system interfaces, the test environment must also include copies of other system's files and/or software involved in the interfaces. Inventory all software and data stores of other systems that will be duplicated in the test environment.

Outline procedures for creation, maintenance and rebuilds of the test environment. Describe controls to maintain the integrity of the test data and prevent unauthorized rebuilds.

E.1.24 Deliverable 6.2 – Acceptance Test Plan

Overview: This Deliverable shall elaborate on the Test Management Plan defined in Section 5.16, Deliverable 4.5. It will outline how the objectives of the Test Management Plan related to Acceptance Testing will be achieved. At a minimum, the Deliverable shall include:

E.1.24.1 Test Preparations

This section will address the following areas. Security and privacy considerations shall be included as applicable.

1. Project-unique identifier of a test – This section shall identify a test by project-unique identifier and shall provide a brief description.
2. Hardware preparation – This section shall describe the procedures necessary to prepare the hardware for the test.
3. Software preparation – This section shall describe the procedures necessary to prepare the item(s) under test and any related software, including data, for the test.
4. Environment preparation – This section shall describe the procedures necessary to prepare and identify the correct version and location of the build being used for testing.
5. Testing tool training – This section shall establish a plan to provide training on the selected testing tool for Acceptance Testing participants.
6. Other pretest preparations – This section shall describe any other pre-test personnel actions, preparations, or procedures necessary to perform the test. Attention should be given to the scheduling of project and DHSS personnel involved in testing and validation of test results, and the securing of the testing location.

E.1.24.2 Test Descriptions

Testing to simulate workflow shall be included to ensure business performance is achieved. Security and privacy considerations shall be included as applicable. At a minimum, this section shall address the following areas:

1. Project-unique identifier of a test case.
2. Requirements addressed.
3. Prerequisite conditions.

4. Test inputs.
5. Expected test results.
6. Criteria for evaluating results.
7. Test procedure.
8. Assumptions and constraints.

E.1.24.3 Defect/Issue Tracking Tools

The DHSS requires that the Contractor provide and maintain a Defect/Issue Tracking Tool for DDI and the remainder of the SDLC. DHSS and its designees must be allowed access to this tool at the DHSS's discretion. The Contractor shall deliver a tool that provides, at a minimum:

1. Online accessibility to track identified defects and issue both local and remote.
2. The status of each defect/issue with regard to findings, percentage of completion and resolution.
3. Documented results of the correction efforts and the final result.
4. The prioritized status of defects/issues.
5. Summary and detailed reporting on all defects/issues in Excel formats.
6. Supporting attachment capabilities (e.g., scanned documents, documents, and spreadsheets).
7. The ability to cross reference each defect/issue to the RFP requirements or the RTM.
8. Integration with the technical and non-technical artifact management repository.
9. Integration with the workflow tool to route and alert the necessary staff members.

E.1.24.4 Requirements Traceability

This section will be divided to addresses the following areas. Security and privacy considerations shall be included, as applicable.

1. Traceability from each test case to the system or requirements it addresses. If a test case addresses multiple requirements, the traceability must be established for each set of test procedure steps to the requirement(s) addressed.
2. Traceability from each system or requirement to the test case(s) it addresses.

E.1.25 Deliverable 6.3 – Acceptance Test Results

Overview: This Deliverable requires execution of Acceptance Testing and describes the content and repository for test results from user acceptance testing. The acceptance testing test results shall be evaluated on structured system testing. All defect corrections must be thoroughly tested and approved by the DHSS prior to implementation of the change. At a minimum, the Deliverable shall include:

E.1.25.1 Overall Assessment of the Software Tested

This section shall:

1. Provide an overall assessment of the software as demonstrated by the test results in this report.
2. Identify any remaining deficiencies, limitations, or constraints that were detected by the testing performed. Problem/change reports may be used to provide deficiency information.

For each remaining deficiency, limitation, or constraint, describe its impact on software and system performance, including identification of requirements not met. Also, the following should be addressed:

1. The impact on software and system design including other correlating factors that might influence the correction process.
2. A recommended solution/approach for correcting the identified error

E.1.25.2 Impact of Test Environment

This section shall provide an assessment of the manner in which the test environment may be different from the operational environment and the effect of this difference on the test results.

E.1.25.3 Recommended Improvements

This section shall provide any recommended improvements in the design, operation, or testing of the software tested. A discussion of each recommendation and its impact on the software may be provided.

E.1.25.4 Detailed Test Results

This section shall describe the detailed results for each test. It will include test number, summary of test results, problems encountered, identification of test procedure step(s) where problems occurred, reference to backup material as appropriate, deviations from test cases/procedures, and an assessment of the deviations' impact.

E.1.25.5 Test Log

This section shall present, possibly in a figure or appendix, a chronological record of the test events covered by this report. This test log shall include at a minimum:

1. The date(s), time(s), location(s), and tester(s) of the tests performed.
2. The hardware and software configurations used for each test.
3. A record of DHSS signoff on the completed and successful tests.

E.1.26 Deliverable 6.4 – Operational Readiness Testing (ORT)

Overview: During the testing phase, an operational readiness test plan and schedule is required to assess the readiness of FA operations and the competency and proficiency of the Contractors staff. The Contractor will prepare and present the plan in a format that is acceptable to DHSS prior to actually executing the plan. The plan must address at a minimum:

1. The identification all inputs and workflows into and through each business process being tested.
2. Load testing and its results.

3. Staff readiness testing, and communications testing to ensure the Contractor and Solution are ready to perform.
4. Basic functions such as:
    a. Processing all inputs.
    b. Pricing claims correctly.
    c. Enrollment and eligibility and capitation processing.
    d. Execution of claim adjustments and voids.
    e. Customer service and correspondence management.
    f. Drug rebate.
    g. Banking and check processing functions and security features.
    h. Mailroom and intake functions.
    i. Provider functions and interfaces.
    j. Electronic document management.
    k. All reporting requirements.
5. The use of a properly functioning data communications network.
6. Meeting system performance and operational performance requirements.
7. Volume testing including at least 30 days of production capacity and claim record volumes.
8. Backup capacity and verification of data security and fire/disaster prevention and recovery procedures.

The disaster recovery processing portion of the operational readiness test will be limited to a recovery during a daily and a weekly process cycle. The length of the test will be the amount of time that is necessary to recover from the disaster and provide proof that the recovery has been successfully completed.

The Contractor shall perform other operational readiness demonstrations at the discretion and direction of the State, to ensure operational readiness.

E.1.27 Deliverable 6.5 – Operational Readiness Test Report

The Contractor must submit a report that details the results of the operational readiness tests and assessments. It certifies that the entire DMES and its: functions, processes, operational procedures, staffing, telecommunications, and all other associated support is in place and ready for operation.

At the end of each phase of testing, the Contractor must summarize the results of the testing in a Final Testing Report, which will include:

E.1.27.1 Assessment of Operations Tested

This section will summarize the testing process and provide:

1. An overall assessment of the business operation as demonstrated by the test results in this report.

2. Identify any training, resource or operational deficiencies, limitations, or constraints that were detected by the testing performed. Problem/change reports may be used to provide deficiency information.

For any training, resource, or operational deficiency, limitation, or constraint, describe its impact with regard to:

1. Meeting key operational performance indicators or standards.
2. Other dependent business operations.
3. Identifying requirements that were not met.
4. Identify the effort and timeline to remedy the cause.

E.1.27.2 Impact of the Test Environment

This section shall assess the manner in which the test environment may have been different from the operational environment and the effect of this difference on the test results.

E.1.27.3 Recommendation for Improvement

This section shall discuss recommendations for improving: training curriculum for staff, staff preparedness and skill level, and workflow design, of the operation tested. A discussion of each recommendation and its impact on the operation may be provided.

E.1.28 Deliverable 7.1 – Training Strategy

Overview: Describes the Contractor's approach to identifying and meeting training requirements. The Training Strategy will describe the methods proposed to develop and deliver both training and related documentation and will include a discussion of the Contractor's understanding of DHSS training requirements. The Training Strategy will be reviewed as part of acceptance testing to verify accuracy, comprehensiveness, understandability, and usability. The strategy will address at a minimum the training requirements for users and technical staff for both pre- and post-implementation periods. The Contractor must also demonstrate their understanding of Delaware's provider community and provide a general description of the strategy for provider training.

E.1.28.1 Introduction

This section will describe the Contractor's training strategy. The training strategy will focus on two comprehensive training activities: a) Contractor and DHSS user and technical support staff training and b) DMAP Provider training. This section shall include:

1. Training course objectives.
2. Contractor's role in training.
3. Time frames in which training must be accomplished.
4. Methods for training (e.g., classroom, Internet-based).
5. Contractor's approach to providing training for data conversion, acceptance testing, implementation, provider support, and post-implementation.
6. Contractor's approach to providing training for provider support, pre and post-implementation.

7. Approach to providing training across the state (localized training, train-the-trainer, etc.).

E.1.28.2 Training Requirements

This section will describe the general work environment (including equipment) and the skills for which training is required. This section will refer to:

1. Identification of training audience/groups.
2. Statement of how the Contractor's training role and training-related tasks will vary within the multiple tasks identified in the project.
3. Description of how the Contractor's training materials and training facilities will be ADA compliant.
4. Type of training to be developed.
5. Projected training schedule.
6. Method of delivering training.

E.1.28.3 Training Resource Requirements

This section will identify the essential resources known to be associated with the specified training including staff, space, equipment, and training aids.

E.1.28.4 General Content of Training Materials

This section will present content of proposed training materials, courses and documentation.

E.1.28.5 Evaluation

This section will describe the process that will be used to assess the effectiveness of training that is provided and to adjust training methods as required.

E.1.28.6 Communication Approach

In this section, the Contractor will describe its approach to Training Strategy change readiness and Training communication plans.

E.1.29 Deliverable 7.2 – Training Plan

Overview: This deliverable requires a description of the purpose, content and organization of the training plan. A training planning session must be held to review the training plan prior to the first actual training session.

E.1.29.1 Introduction

This section will provide an overview of the Training Plan. At a minimum, the overview will:

1. Describe the group(s) who will receive training.
2. Identify the objectives or expected results of the training, including actions user will be able to perform following training.
3. Provide an overview of the training curriculum.
4. Identify sources of information used to develop the training plan.

E.1.29.2 Training Methods

This section will describe the Contractor's training methods. Instructor-led real-time synchronous technology shall be utilized whenever possible. This Section shall include:

1. Methods for training (e.g., classroom, blended approach, distance learning, Internet-based).
2. Approach to providing training across the state (localized training, train-the-trainer, etc.).

E.1.29.3 Training Logistics

The Contractor shall describe the training logistics and the skills required for trainers. This section will, at a minimum, include the following:

1. Schedule including duration, sites, and dates.
2. Roles and responsibilities of the training staff.
3. Identification of persons or groups who may serve as trainers or training consultants.
4. Description of how training evaluation will be performed, including tools, forms, etc.

E.1.29.4 Training Environment and Resources

The Contractor must provide training, not only on the COTS software, but also on any additional software products required to support the Contractor's proposed solution and as necessary any training on the various hardware and network components used during operations (i.e., scanners or mobile devices). This Section will identify all essential resource requirements associated with training, to include, at a minimum, the following:

1. Facilities.
2. Hardware/software.
3. Special hardware/software access apart from full production environment.
4. Instructor availability.
5. Projected level of effort.
6. Strategy for coordinating registration and tracking of students using DHSS' Learning Management system.
7. System documentation and other resources required to familiarize the trainer with the system, produce training materials, and provide the actual training.
8. Post-implementation staffing for training and application advice/mentoring.

E.1.29.5 Training Materials

This section will describe the types of training materials that will be developed for technical training. Training materials may include visuals, handouts, workbooks, manuals, computerized display, and demonstrations. These materials will:

1. Follow a functional, workflow approach to learning the system with a focus on "hands-on" examples.
2. Accurately reflect the system as it functions.
3. Include preparation of an instructor guide for use in subsequent training.

4. Include a process for revision as system modifications are implemented or as additional training needs are identified.

E.1.30 Deliverable 7.3 – Training Environment

Overview: This deliverable requires a description and creation of the training environment, including equipment for State personnel, providers, and other stakeholders. As stated in the RFP, the Contractor shall provide a training facility to support DMES training in the New Castle region. The Contractor will develop training capabilities that can be duplicated and deployed to other DHSS locations throughout the state. This deliverable will be provided to DHSS before invoicing for Training Environment components.

As part of the proposal, the Contractor shall respond to this Section by describing the training environment, including the following at a minimum:

E.1.30.1 Training Environment

1. Describe the equipment and conditions required for the training, including installations, facilities, locations, and special databases.
2. Describe approach to distance learning and registration; include software tools required.
3. Describe class sizes.
4. Identify any actions required by other groups, such as users, to ensure all equipment is in place and specified conditions are met before the training.
5. Describe how ADA requirements will be met.

E.1.31 Deliverable 7.4 – Training Materials

Overview: This deliverable describes and requires delivery of training materials that will be developed for user training. Training materials may include visuals, handouts, workbooks, manuals, computerized display, and demonstrations.

Training materials must be designed for hands-on use in a classroom, lab situation, or for future reference by users when the system is operational. All training materials become the property of DHSS and must be reviewed and approved by the State before the start of the training. All training will be supported with a specific set of training materials. At a minimum, the Deliverable shall include:

E.1.31.1 Types of Training Materials

As part of the proposal, the Contractor shall respond to this section by describing its training materials, including the following:

1. Training manuals that parallel the content of user and procedure manuals.
2. Samples of training course outlines, instructors' classroom materials, training packets, presentations, and related documentation.
3. Description of training materials development, including alternate formats and provisions for an interpreter for people with vision and hearing impairments.
4. User training manual and training materials.
5. Instructor guides.

6. Provider manuals and training materials.
7. Development and distribution of instructional materials.
8. Classroom exercises.
9. Glossary.
10. Descriptions of audio/visual presentations and web-based tutorials.

E.1.31.2 Content of User Training Materials

User training curricula and materials will cover, at a minimum, the following topics:

1. System overview.
2. System benefits.
3. Data inputs, outputs, and reports generated.
4. Major system business functions.
5. User manual contents and usage.
6. System Usage.
7. Entering data and data validation.
8. Data correction and user help features.
9. Menu and system function traversal.
10. Problem recovery.
11. Report usage, content, location, and generation.
12. Search and inquiry features.
13. Record-update procedures.
14. System operation.
15. Seeking technical help.
16. Application and equipment assistance.

E.1.31.3 Update/Revise Training Materials

Once training materials are developed, they must be stored in the Project Repository, Deliverable 1.5 as described in Section 5.4, and subjected to the same kind of configuration management process as the other system documentation. Training materials shall remain current with system enhancements.

E.1.32 Deliverable 7.5 – Training Report

Overview: This deliverable will describe the method for reporting, reviewing, and correcting discrepancies identified during trainings. The Contractor will include the following at a minimum:

1. Names of persons trained.
2. Training date.
3. Length of training.

4. Contractor comments regarding the training session.
5. List of persons who were scheduled for training who did not attend.
6. Identify discrepancies identification and resolution.

E.1.32.1 Evaluation

This section will identify evaluation results regarding the effectiveness of the training and will use the industry standard Kirkpatrick Model which includes the following information:

1. Level 1: Assess learners' initial reaction to a course (100% of training).
2. Level 2: Assess the extent to which learners achieved the objectives (50-60% of the training).

E.1.33 Deliverable 8.2 – Production Environment

Overview: This deliverable requires the description and creation of the Production Software Environment by the Contractor to support all of DHSS's requirements for a new DMES. The Production Environment must be robust and capable of supporting approximately 400 State users and 8,000 DMAP providers who have daily access to the system. This deliverable will be provided to DHSS before invoicing for Production Environment components.

E.1.33.1 Production Environment

This document shall inventory the hardware, software, network, communication and data storage components necessary to support the DMES and its users to the level specified in Performance Standards in the Attachment L – Contract Terms and Conditions. This document shall also outline how the Contractor will ensure that all components of the architecture are compatible and can handle the capacity requirements specified in SOW Section 3.

The Production Environment must be able to support all interfaces with DHSS legacy systems and external entities and must integrate into the existing DHSS technical architecture. This document shall contain a platform architecture schematic that illustrates the technology components of the DMES and how State users, providers and others accomplish access to the system.

E.1.34 Deliverable 8.7 Implementation Certification Letter

The Contractor will be required provide an implementation certification letter that certifies that the system is ready for production. The Contractor must describe the preparation and QA process to assure the following requirements addressed in the certification letter have been properly addressed:

1. Completion of all technical and non-technical training activities as approved by DHSS.
2. All data has been converted, cleaned, tested, and accepted.
3. All critical defects have been addressed with a plan to prioritize and remediate those defects yet to be addressed.
4. All site preparation requirements have been met.
5. Help desk is established.
6. All user and system supports are in place.

7. All production jobs have been through the version control process and locked down in production libraries.
8. All production databases have been appropriately sized and are ready for production processing to begin.

E.1.35 Deliverable 9.1 & 12.1 – Operations Quality Management Plan

Overview: The Quality Management Plan (QMP) encompasses planning for, managing, and executing the operations of the new DMES by the Contractor. The QMP shall address: routine day-to-day operational support tasks, key performance measures and indicators established under the Master Service Level agreement, as well as how to monitor, and audit these tasks. Deliverable 9.1 will detail the plan that will support the Contractor's Quality Management Program for the operations of the new DMES excluding the POS-PBM; Deliverable 12.1 will address the QMP plan for operations of the POS-PBM. At a minimum, the Deliverable shall include:

E.1.35.1 Scope

This section will identify the scope of the QMP that will be developed by the Contractor to identify tools, resources and administrative requirements and demonstrate compliance for on-going support of the program. This will expand the outline included in the Project Management Approach deliverable 1.1.

The PMBOK® Guide (Fourth Edition) breaks down the project quality management plan into three interactive process groups:

1. Plan Quality.
2. Perform Quality Assurance.
3. Perform Quality Control (QC).

E.1.35.2 Plan Quality

The quality planning process applies to plans, documents, products and services, programs and operational functions. In addressing its approach to plan quality, the Contractor will:

1. Identify which quality requirements and standards are relevant to the project and how to satisfy them.
2. Identify and define appropriate quality metrics and measures to establish standards for:
    a. Business processes.
    b. Product and service functionality.
    c. Regulatory compliance requirements.
    d. Deliverables.
    e. Management performance.
    f. Documentation.
    g. Reporting.
    h. Testing.

3. Identify quality standards and expectations for: customers, the project, organization and federal and State mandates and initiatives including:
    a. CMS guidelines such as MITA V2.01 and V3.0.
    b. Health Benefit and Health Insurance Exchange IT guidance.
    c. ARRA and ACA Medicaid Initiatives.
4. Define customer and project goals, quality standards, critical success factors, and metrics for which to measure success.
5. Identify monitoring processes and the metrics to measure SLA and other quality standards.
6. Define methods of data collection and archiving, and document timeframes for measurement and metrics reporting.
7. Identify the tools and techniques available to the analyst such as:
    a. Cost benefit analysis.
    b. Statistical sampling.
    c. Flowcharting.
    d. Benchmarking.

E.1.35.3 Perform Quality Assurance

Quality Assurance (QA) is an execution process utilizing data from the Quality Control process. The QA function will be responsible for auditing existing controls, assessing the controls to determine if the desired results are being realized, ensuring that proper procedures are being followed, and performing specialized audits as necessary. To adequately perform the QA process the Contractor must explain how it plans to:

1. Audit the quality requirements and the results from the quality measurement initiatives identified in the Plan Quality Process group.
2. Provide consistent and systematic measurement comparison with standards.
3. Monitor processes and associated feedback loops that confer error prevention.
4. Ensure and provide assurance to the State that service delivery meets or exceeds the quality standard requirements.
5. Analyze quality data, document opportunities for improvement and apply what was learned from quality analysis to eliminate gaps between current and desired levels of performance.

QA activities will be performed by a QA unit or similar organization not actively involved in the work of the project. These activities may be performed in support of the project team, project stakeholders, the project sponsor, project steering committee or management. The Contractor must identify in its development of the quality assurance plan, the unit singly responsible for performing the QA function for the remaining phases of the SDLC.

In addition to the QA activities indentified above, the Contractor will explain QA unit responsibilities for:

1. Making recommendations for continuous process improvement.
2. Developing audit strategies.

3. Develop Surveys targeted to stakeholders.
4. Initiating corrective actions.
5. Organizational process asset updates including documenting and publishing; QA policies, desk level procedures, guidelines and lessons learned.
6. Initiating change requests that improve performance.
7. Validating SLA performance metrics and system generated quality monitoring tools to ensure accuracy.
8. Submitting monthly reports and findings to DHSS to be combined with the bi-monthly status report requirement.

E.1.35.4 Perform Quality Control

Quality Control is performed throughout the project and employs activities and methodologies by the Contractor to observe and correct process variance or abnormality and ensure consistency in performance so that service quality requirements will be fulfilled. The Contractor will explain how Quality Control processes will be performed to include the following:

1. Identify those monitoring and controlling actions that will be conducted to control quality of deliverables and operational performance.
2. Define how it will be determined that quality standards comply with the defined standards outlined earlier in this document.
3. Identify owners of ongoing monitoring and improvement of project processes.
4. Examine the work product to determine if it complies with the documented standard.

The QC plan will prioritize those activities that are designated as critical to FA operations and to the SLAs established by the master SLA agreement. The plan may be amended from time to time with the prior approval of DHSS.

The Contractor must address at a minimum the following areas with regard to performing quality assurance and quality control efforts:

1. Deliverables.
2. Provider and Client Customer Service.
3. Reporting (internal and external).
4. Solution delivery.
5. Module and System component maintenance.
6. Change management and system component modifications.
7. System Documentation.
8. Testing activities.
9. Operational processing.
10. Claims processing and data entry.
11. Version control.

E.1.36 Deliverable 9.2 & 12.2 – Fiscal Agent Staffing Requirements Capability Report

Overview: The Fiscal Agent Staffing Requirements Capability Report addresses the Contractor's approach and strategy to fulfill the staffing requirements for FA operations. The Contractor's approach should suffice to re-enforce the strategies employed in the QMP in deliverable 9.1 and comply with all QMP initiatives and operational requirements; Deliverable 12.2 will address staffing requirements for Pharmacy Benefit Management FA Services. The report will be prepared semi-annually. At a minimum, the Deliverable shall include:

E.1.36.1 Approach to Preparing the Report

This section will describe the Contractor's approach for determining the number and knowledge/skill level of staff necessary for supporting on-going FA operations, and the Quality Management Program requirements for the new DMES. This report will be evaluated and updated annually.

E.1.36.2 Organization Charts

This section will contain an organization chart for FA operations including QMP support and will identify the following:

1. Reporting structure.
2. Named Staff.
3. Position Titles.
4. Number and type of Categorized Staff assigned.

E.1.36.3 Named Persons

This section will identify the Contractor's key personnel and will include the following information for each key person:

1. Name.
2. Position Title.
3. Functions to be performed by the position.
4. Knowledge/skills required for the position.
5. Qualifications of the incumbent.

E.1.36.4 Support Team

This section will identify categorized labor for all staff assigned to the account and will include the following information for each position:

1. Position Title.
2. Required Skills.
3. Operations and quality functions performed.
4. Number of Categorized Staff assigned in this category.

E.1.36.5 Recruitment and Training

This section will describe the Contractor's recruitment and training procedures. This will include information pertaining to:

1. Ensuring support staff has the knowledge/skills necessary to perform effectively in the DMES environment.
2. Retention policy or methodology.
3. Providing routine training and orientation to new staff.

E.1.36.6 Cross Training Staff

This section shall describe where in the organizational structure this type of training will be performed and for whom it will be received (if not individual names, then at least roles attached to specific training plans).

E.1.37 Deliverable 9.3 11.3 & 12.3 – Weekly Project Status Report

Overview: The Weekly Project Status Report (PSR) must conform to reporting practices as described in PMBOK® Guide (Fourth Edition). Deliverable 9.3 will address status reporting for FA operations core functions and system components. Deliverable 11.3 will address status reporting for system operation and maintenance support. Deliverable 12.3 will address status reporting for POS – PBM FA operations. The reports may be consolidated into separate sections of a combined weekly report. At a minimum, the deliverable shall include:

E.1.37.1 Format and Focus

The Contractor shall submit to the State a weekly project status report. This report is to be submitted in writing and shall provide a summary of the previous weeks' activities. The report shall also address any problems or concerns identified by the Contractor staff or the Quality Management Team and shall briefly describe scheduled activity for the next week. The report is to be delivered to DHSS no later than 4:00 p.m. EST on the second business day of the following week. It shall include, but not be limited to:

1. Production output by business area as applicable.
2. Call center and mailroom statistics.
3. Banking statistics including number of payments processed (paper check and EFT), reconcilable items (e.g., stale dated transactions, liens and levies, stop payments, deposits, damaged check stock).
4. Claims processing statistics.
5. Output from the activity tracking and management system.
6. Performance metrics and statistics including, but not limited to, help desk statistics, system uptime information, and other items related to the performance standards specified in the Contract.
7. Output resulting from QA activities performed by the QA Unit (incorporated monthly).
8. Joint Technical and Management Review finding.
9. PBM, Pro-DUR and Drug Rebate activities.
10. Other as defined by the State.

Given that this weekly report, emphasis on reporting certain issues may change based on the States focused interests. The Contractor will make accommodation for reporting changes based on these interests However, at a minimum, the PSR will summarize schedule performance and budget performance to compare actual project performance with plan.

E.1.38 Deliverable 9.4 11.4 & 12.4 – Annual Status Report

Overview: An annual report is to be provided to the State not later than one month after the conclusion of each Contract year and is to cover the previous Contract year. Work request activity during the year shall reflect major accomplishments as well as any minor points of interest. The annual report shall provide a prospective view in addition to the retrospective view so that the State can anticipate any potential activity that the Contractor feels is necessary to keep FA operations as efficient as possible. Deliverable 9.4 will address annual status reporting for FA operations core functions and system components. Deliverable 11.4 will address system maintenance and operations support initiatives for the past and coming fiscal year including keeping the DMES as efficient as possible. Deliverable 12.4 will address annual status reporting for POS – PBM FA operations. The reports may be consolidated into separate sections of a combined annual report.

E.1.38.1 Report Content

For this annual report, the format shall break down its prospective and retrospective views according to the approved service areas noted in the RFP for FA Operations and System Operations and Maintenance Support activities. At a minimum, the deliverable shall include:

1. Summary of key events for the year, including account changes that happened in the past year, modifications to Named Persons, and planned personnel changes for the upcoming year.
2. Summary of any contractual issues that arose and how they were resolved. Include any anticipated contractual changes, either through renegotiated statement of work or through Contract amendments.
3. Summary analysis of service level performance and key performance indicators vs. planned or expected performance.
4. Summary of the results of systems operations for the year including a summary of performance and volume statistics, issues tracking and resolution, staffing changes, and planned staffing changes.
5. Summary of the enhancements and modifications made to the new DMES and its components over the course of the year. The review of this shall also include: a staffing analysis evaluating staffing efficiency in conjunction with the staffing skills and experience that were matched to perform the work tasks, proposed staffing changes or staff focus, and expected staffing changes and resource shifts between enhancement and maintenance work.
6. Summary of the maintenance activities and planned ongoing and key maintenance activities for the coming year, including appropriateness of staffing and past and predicted staffing changes and resource shifting.
7. Help Desk recap, including the number of calls handled by the Contractor's Level 2 help desk team and the results of those ticket assignments, an assessment of how the help desk process is working including interaction with DHSS Level 1 & 2 support staff with suggestions for improvement, and a staffing report with past and expected staffing changes.
8. Summary of any hardware, software, and 3rd-party services acquired in the past year and planned for the upcoming year.
9. Impact Statement Summary.

E.1.39 Deliverable 10.1 – Certification Checklist

Overview: The DMES certification encompasses the production and delivery of final systems documentation, preparation for, and obtaining federal certification of the new DMES. At a minimum, the Deliverable shall include:

E.1.39.1 Certification Approach

Preparation for certification shall include developing and assembling documents that will be used to support the certification process and review. This deliverable shall describe the Contractor approach to achieve certification by addressing the Contractor responsibilities that are outlined below.

1. Follow the preparation guidelines in the Medicaid Enterprise Checklist Toolkit (MECT, also referred to as the Toolkit), or its successor, in preparing the DMES and DHSS management for the Certification.
2. Review checklist criteria that identify specific requirements that must be met after a complete review of the State Medicaid Manual.
3. Review of other reference documents or contacts with other state staff recently involved in certification review.
4. Identify and review other project deliverables that will be used in certification.
5. Identification of other documents that will be required for certification that will need to be assembled or created.
6. Archive first-run test claims and reports until receipt of certification.
7. Resolve any deficiencies identified during certification review.
8. Process to be used to assemble, update and library requirement deliverables.

E.1.39.2 Certification Checklist Criteria

The certification checklist shall contain, but is not limited to:

1. A crosswalk of federal requirements to certification deliverables (system documentation, reports, walk-through books) and explanation of form and content of the deliverables.
2. Delineation of responsibilities between DHSS and the Contractor in completing certification.

E.1.40 Deliverable 10.2 – Certification Review Package

This deliverable requires CMS certification for final acceptance. The Certification Review Package, the final product of documentation requirements identified in the Certification Checklist and Readiness process, will be used to obtain certification of the new DMES. The Review Package will include the components described below.

This section will describe the documents the Contractor will prepare in support of the onsite review. This package will be submitted to DHSS with a written statement of intent to claim enhanced Federal Financial Participation. DHSS will be responsible for submitting the approved review package to CMS. This package will include, at a minimum:

1. Confirmation that system operations meet requirements and performance standards as specified in the State Medicaid Manual Part 11, Chapter 3.

2. Copy of system acceptance letter to the Contractor from DHSS.
3. System documentation including:
    a. System Documentation Version 3, Deliverable 8.6.
    b. Source Code Library Version 3: Production Environment, Deliverable 8.3.
    c. User Manual Version 2, Deliverable 8.4.
    d. Operating Procedures Version 2, Deliverable 8.5.
    e. Acceptance Test Plan, Deliverable 6.2.
    f. Acceptance Test Results, Deliverable 6.3.
    g. Substantive and representative sample of reports.
4. Documentation for onsite review:
    a. First-run DMES reports.
    b. Documentation, which may be requested by CMS following the preliminary review.
    c. MECT Checklists.

E.1.41 Deliverable 11.1 – System Operation & Maintenance Support Plan

Overview: The Contractor will annually provide a DMES Support Plan which will provide the State transparency into the management and execution of systems operation and maintenance for the new DMES. The plan shall detail routine system support tasks as well as how to manage enhancements to the system. Deliverable 11.1 will detail the plan for the information systems operations and maintenance of the new DMES including all modules and system component (e.g., POS – PBM). At a minimum, the Deliverable shall include:

E.1.41.1 Scope

This section will identify the scope of the Systems Support Plan that will be developed by the Contractor to identify resource and administrative requirements for on-going support of the system. This will expand the outline that was included in the Implementation approach deliverable and is related to the Change Management Plan.

E.1.41.2 Production Operation Support

This section will address production systems support requirements, including the managerial and technical services required to manage and operate the replacement DMES. This includes, but is not limited to, the following:

1. Batch cycle scheduling specification, including job turn-around time monitoring.
2. Database administration.
3. Coordination and consultation with applications software and testing teams.
4. Database standards identification and compliance monitoring
5. Database maintenance, reorganization, and recovery.
6. Data queries and corrections.
7. Database performance analysis and improvement.

8. Database resource utilization and capacity planning.
9. Performance tuning.
10. Problem identification.
11. Software release and emergency implementation.
12. Software quality assurance evaluation.
13. System resource forecasting.
14. Performance monitoring.
15. Software migration.
16. DMES security implementation and monitoring.
17. Mainframe liaison support with DHSS.
18. Maintaining required interfaces, including file format and regular exchange of data according to requirements defined by DHSS.

E.1.41.3 System Maintenance Resource Requirements

This section will address system maintenance resource requirements resulting from a determination by DHSS or the Contractor that a deficiency exists in the system or that improved efficiency can be achieved through software or hardware modifications; including, but not limited to:

1. Activities necessary to correct a deficiency within the operational DMES, including deficiencies found after implementation of modifications incorporated into the DMES.
2. Activities necessary to ensure that all data, files, program, and documentation are current and errors are found and corrected.
3. File maintenance activities for updates to tables and databases.
4. Changes to operations parameters concerning the frequency, quality, format, sorting media and distribution of reports.
5. Changes to edit disposition parameters for established edit or audit criteria.
6. Addition of new values or changes to existing values in all system tables.
7. Activities necessary to meet DTI standards or policies.

E.1.41.4 System Enhancement Resource Requirements

This section will address system enhancement resource requirements resulting when DHSS or the Contractor determines that new functionality or significant changes to existing system functionality will be completed. This includes, but is not limited, to:

1. Activities necessary for the system to continue to meet the requirements of DHSS.
2. Activities necessary to continue to meet CMS certification requirements existing at the time of Contract award and ongoing standards.
3. Implementation of capabilities not contemplated in the RFP nor agreed to during the design and development tasks.

4. Implementation of audits and edits not defined in the RFP, current operating system and acceptance by DHSS.
5. Changes to established report, screen, or file formats, new data elements, or report items.
6. Acceptance of a new input form.

E.1.41.5 Activity Tracking and Reporting

This section will present the Contractors plan for providing or using DHSS's automated online software management system for tracking and reporting all system maintenance and modification projects with full accessibility by DHSS. This plan will contain, at a minimum, the following elements:

1. Identification of a defined set of software development and management indicators; including, but not limited to:
    a. Project description and priority.
    b. Dates requested, estimated and required.
    c. Requestor.
    d. Assigned resources.
    e. Estimated hours to complete.
    f. Project status including hours worked and estimated by change control.
    g. Methods used to evaluate these data.
    h. Description of standard reports to be viewed on line.
    i. Options for producing reports of varying content and format.
    j. State SME.

E.1.41.6 System Maintenance and Enhancement Processing

This section will present the Contractor's plan for processing system maintenance and enhancement tasks as described in Attachment D – DMES Systems Operations and Maintenance Tasks, including, but not limited to:

1. Notification of DHSS that a system problem has been identified or a change is needed in order to improve system operations or accuracy.
2. Receiving system change requests from DHSS.
3. Logging change requests and status into the project tracking and reporting system.
4. Development of requirements specification documents.
5. Establishing task priorities.
6. Development of test plans and procedures for acceptance by DHSS.
7. Performing tests and submitting test results.
8. Submission of updated systems documentation for approval.
9. Implementation of system changes and validation.

E.1.41.7 Technical and Management Reviews

This section will describe the Contractor's plan for conducting technical and management reviews involving appropriate Contractor and DHSS staff. These reviews will be held routinely to address system objectives relating to software installation and project status.

E.1.41.7.1 Joint Technical Reviews

This section will address the plan for technical reviews involving staff with technical knowledge of software products to be reviewed. These reviews will focus on in-process and final software products. The reviews will have the following objectives:

1. Review evolving software products to verify the proposed technical solution and obtain feedback on open issues.
2. Review project status, risks, and schedule issues.
3. Develop risk mitigation strategies.
4. Identify risks and issues to be raised to joint management reviews.
5. Ensure ongoing communication between DHSS and Contractor technical staff.

E.1.41.7.2 Joint Management Reviews

This section will address the plan for joint management reviews involving staff with authority to make cost and schedule decisions. These reviews will have the following objectives:

1. Review project tracking reporting to assess project status, directions being taken, technical agreements, and emerging issues.
2. Resolve issues that could not be resolved at joint technical reviews.
3. Arrive at agreed upon mitigation strategies for near and long term risks that could not be resolved at joint technical reviews.
4. Identify and resolve management-level issues and risks not raised at joint technical reviews.
5. Obtain commitments and approvals needed for timely accomplishment of tasks and projects.

E.1.42 Deliverable 11.2 – Staffing Requirements Capability Report

Overview: The Operations and Maintenance (O&M) Staffing Requirements Capability Report will encompass the staffing requirements and approach for the Contractor to fulfill the System O&M Support Plan and contractual obligations under the DDI Contract as well as any future related amendments and change orders. This report shall be delivered semi-annually. At a minimum, the Deliverable shall include:

E.1.42.1 Approach to Preparing the Report

This section will describe the Contractor's approach for determining the number and knowledge/skill level of staff necessary for supporting on-going operations, maintenance, and enhancement requirements of the DMES. This report will be evaluated and updated annually.

E.1.42.2 Organization Charts

This section will contain an organization chart for system support and will identify the following:

1. Reporting structure.
2. Named Staff.
3. Position Titles.
4. Number and type of Categorized Staff assigned.

E.1.42.3 Named Persons

This section will identify the Contractor's Named Persons and will include the following information for each key person:

1. Name.
2. Position Title.
3. Functions to be performed by the position.
4. Knowledge/skills required for the position.
5. Qualifications of the incumbent.

E.1.42.4 Support Team

This section will identify the labor categories for all staff assigned to the account and will include the following information for each position:

1. Position Title.
2. Required Skills.
3. Operations, maintenance or enhancement functions performed.
4. Number of Categorized Staff assigned in this category.

E.1.42.5 Recruitment and Training

This section will describe the Contractor's recruitment and training procedures. This will include information pertaining to:

1. Ensuring support staff has the knowledge/skills necessary to perform effectively in the DMES environment.
2. Minimizing staff turnover.
3. Providing routine training and orientation to new staff.

E.1.42.6 Cross-training Staff

This section shall describe where in the organizational structure this type of training will be performed and for whom it will be received (if not individual names, then at least roles attached to specific training plans).

E.1.43 Deliverable 11.5 – System Updates

Overview: This deliverable shall describe the approach and process the Contractor will take with regard to updating the system and associated documentation. At a minimum, the Deliverable shall include:

E.1.43.1 General Process

This section describes the Contractor's general approach to updating system documentation, including general methodology for updating and reviewing documentation. The Contractor will discuss the tool used for storing and updating documentation, the method used for version control, and when and how often documentation will be updated. For each version release of the documentation, the Deliverable that served as the catalyst for the change shall be referenced:

1. Requirements Document, Deliverable 2.1.
2. System Architecture and Design, Deliverable 4.1.
3. Test Plans, Deliverables 4.3 and 7.2.
4. Testing Results, Deliverables 5.3, 6.3, and 7.3.
5. User Manual, Deliverable 9.4.
6. Operating Procedures, Deliverable 9.5.
7. Source Code Library, Deliverable 9.3.
8. Training Materials, Deliverable 10.4.

E.1.44 Deliverable 11.6 – Operations and Maintenance Procedure Manual

Overview: The Operations and Maintenance Procedure Manual shall provide detail regarding the provisions of operations and maintenance services. The Manual outlines how operations are being performed, addressing account management services, staffing, systems operations, system change, enhancement and modification, system general and routine maintenance, problem tracking and resolution, help desk services, and hardware/software acquisition. At a minimum, the Deliverable shall include:

E.1.44.1 Account Management Services Overview

This section will provide an overview of the Contractor's approach to Account Management. This will include coordination and reporting on ongoing system operation and maintenance.

E.1.44.2 Enhancement and Modification of the System

This section will describe the Contractor's methodology to addressing system changes, enhancements and modifications. At a minimum, this section will address the following elements:

Approach to maintaining the MMIS according to DHSS-approved requirements, including:

1. Contractor's participation in definition of system modifications and prioritization of system change requests.
    a. Correction of system errors.

   b. Managing preparation of Deliverables.
   c. Receiving, recording, and tracking requests.
2. Evaluating and prioritizing requests and obtaining approval to proceed.
3. Planning for and managing enhancement and modification work.
4. Scheduling and monitoring work on enhancements and modifications.
5. Performing testing, including user acceptance testing.
6. Obtaining approval and scheduling implementation.
7. Reporting on status and performance.
8. Keeping documentation updated.

E.1.44.3 System Maintenance (Break/Fix)

This section will address the Contractor's methodology for correcting deficiencies or achieving improved efficiency within the operational MMIS. At a minimum, this Section will address the following elements:

1. Process to identify the need for a maintenance activity.
2. Timeline for addressing system deficiencies.
3. Corrective action plans and approval process.
4. Process to correct errors and discrepancies.
5. Test plans and testing.
6. Implementation of approved modifications.
7. Tracking and status reporting.
8. Updates to Systems documentation and all other necessary documentation.
9. Process to verify successful implementation, including monitoring accuracy of processing, and correction of any problems.
10. Performance monitoring and reporting.

E.1.44.4 Problem Tracking and Resolution

This section will address the Contractor's methodology and approach for correcting deficiencies or achieving improved efficiency within the operational DMES. At a minimum, this Section will address the following elements:

1. How a DHSS or Contractor employee can report a problem.
2. How the problem is assigned for work, including staffing approach.
3. How the problem is tracked to resolution.
4. What is the escalation path and process for problem resolution?
5. What is the communication process associated with closing a problem.

E.1.44.5 IT Help Desk Services

This section will address the Contractor's methodology for providing level three help desk support, including staffing.

E.1.44.6 Acquisition Services for Hardware, Software and Third Party Support Services

This section will address the Contractor's methodology for identifying, proposing, and developing acquisition plans for the acquisition of hardware, software, and third party support services.

E.1.45 Deliverable 13.1 – Turnover Plan

Overview: This deliverable will describe the Contractor's approach and processes for transitioning the DMES operations to another Contractor. The Contractor will develop a Turnover Plan to include at a minimum the following:

E.1.45.1 Content

This section will describe the Contractor's proposed approach to turnover to ensure that essential functions, files, and programs pertaining to the DMES are transitioned to the new contractor without interruption to DMES operations. At a minimum the Contractor shall address and explain the approach to the following tasks in the Plan:

1. A description of the tasks and sub-tasks for turnover.
2. The development of a Project Schedule/WBS as described in Attachment E – Deliverable1.1 for DMES turnover activities.
3. Production program and Documentation update procedures during turnover.

E.1.46 Deliverable 13.2 – Develop a DMES Resource Requirements Statement

Overview: This deliverable will describe the resources that will be to operate the equipment, maintain the software, and perform the other Contractor provided functions of the DMES.

E.1.46.1 Content

Twenty (20) business days following the start of Task 13, the Contractor shall furnish to DHSS a DMES Requirements Statement listing the resources that would be required by DHSS or another Contractor to adequately take over operation of the DMES. The statement of resource requirements shall be based on the Contractor's experience in the operation of the DMES and shall include actual Contractor resources devoted to the operation of the System based on contract requirements and performance agreements. The DMES Requirements Statement must include at a minimum the following:

1. An estimate of the number, type, and salary of personnel required. Named staff must be identified separately by functional area.
2. Personnel information (name, salary/rate, benefits) and access to Contractor's staff for potential hire by DHSS or its designee.
3. Separately identify by type of activity the personnel required to operate and maintain the DMES.

4. Detailed organization chart with names and position titles.
5. Facilities and other resources required to maintain and operate the DMES under the current contract.
    a. Data Processing Equipment.
    b. System and Special Software.
    c. Other Equipment.
    d. Telecommunications Networks.
    e. Office Space.
    f. Other Resources.

E.1.47 Deliverables 13.3 – System Documentation and Source Code Library

Overview: This deliverable will ensure that the turnover of System Documentation and the Source Code Library required to operate the system are provided to the successor FA.

E.1.47.1 Content

Nine (9) months prior to the turnover date, provide a copy of the DMES (Deliverable 13.3) including:

1. All production computer programs, data and reference files, imaged documents, systems documentation on DHSS-approved storage media.
2. All other documentation but not limited to, user and operation manuals needed to operate and maintain the System including:
    a. Operations logs, process summaries, and balancing documents completed during the Contract.
    b. Procedures for updating computer programs, data dictionaries, and other documentation.
    c. System macros used for job scheduling, data entry and System modification functions.
    d. Job scheduling parameters and/or inputs and reports used by operations staff during routine operations.
    e. COTS, Third Party Hardware and software maintenance agreements.

Eight (8) months prior to the turnover date; begin training the staff of DHSS or its designee in the operation and maintenance of the DMES. Such training must be completed at least two (2) months prior to the end of the Contract. Such training shall include:

1. Computer operations, maintenance and enhancement procedures, including performance monitoring procedures.
2. Procedures related to the operations of the Pharmacy POS, as well as other processes related to Pharmacy Benefits Management.
3. Other procedures.

At the turnover date, the Contractor will provide the final submittals of Deliverable 13.3 which include the most recent versions of DMES documentation and software code and the following:

1. Identified work and projects in progress as of the turnover date. With respect to such work, document the current status of work accomplished and define work required to complete the work.
2. Provide Help Desk Tickets and problem logs reporting back at least one (1) year prior to the turnover date. All open Help Desk Tickets shall be addressed as work in progress in the previous paragraph.
3. Transfer security processes and tools including security and password controls.

E.1.48 Deliverable 13.4 – Turnover Results Report

Overview: This deliverable provides an audit of the activities and task that were performed during the Turnover Task to ensure that all activities identified in the Plan were completed as designed.

E.1.48.1 Content

Following the turnover of operations and maintenance responsibilities, the Contractor shall provide DHSS with the following:

1. A turnover Results Report (Deliverable 13.4), which will document completion and results of each step of the Turnover Plan.
2. Ninety (90) day post turnover deliver final banking statements for all closed Medicaid related banking accounts, and banking reconciliations for all settled transactions including an audit of each closed bank account by an independent certified public accounting firm.
3. The Contractor shall provide to DHSS, the services of an onsite senior systems analyst who has worked on the DMES for at least one (1) year. The individual is required to be onsite for the 180 calendar days following turnover. The individual proposed by the Contractor must be approved by DHSS. DHSS will provide working space for the individual and will assign their duties on a full-time basis to support post-turnover activity.

F ATTACHMENT F: GLOSSARY OF TERMS

.NET	(pronounced dot-net) – An initiative by Microsoft to create a new software development platform focused on network transparency, platform independence, and rapid application development
A	
ASC	Accredited Standards Committee
ADA	American Dental Association
ADA	Americans with Disabilities Act
Adjudicate	To determine whether all program requirements have been met and whether the claim can be paid, denied, or suspended or the encounter data would be paid or denied
Adjudicated Claim	A claim that has reached final disposition such that it can either been paid or denied or determined if it would be paid or denied
Adjustment	A transaction that changes any payment information on a previously paid claim
ANSI	American National Standards Institute
APDU	Advance Planning Document Update
API	Application Programming Interface
AR	Accounts Receivable
ASC	Accredited Standards Committee
ASP	Average Sales Price
ASP	Application Service Provider
AVR	Automated Voice Response System – Used to supply recipient eligibility information or claims status to providers via telephone
B	
BCC	Breast and Cervical Cancer Program
BCCP	Business Continuity and Contingency Plan
BENDEX	Beneficiary Data Exchange System – A file containing data from the federal government regarding all persons receiving benefits from the Social Security Administration.
BRMS	Business Rules Management System
Buy-In	A procedure whereby the state pays a monthly premium to the Social Security Administration on behalf of eligible Medicaid recipients, enrolling them in the Medicare Title XVIII Part A and Part B Program
C	
Calendar Day	A 24-hour period between midnight and midnight, regardless of whether or not it occurs on a weekend or holiday
Calendar Year	A 12-month period of time beginning on January 1 and ending on December 31
Carrier	An organization processing Medicare Part B claims on behalf of the federal government
Categorized Staff	Staff positions that must meet qualifications listed in Attachment N – Personnel and also listed by bidder in Attachment K – Cost Proposal.

	These positions do not required staff to be individually named or resumes included in the bidder's proposal.
CBC	Criminal Background Check
CC	Change Control Process / Customer Change – A request to perform a maintenance change or enhance the functionality in the DMES
CD	Compact Disk
CD-ROM	Compact Disk – Read Only Memory
Certification	The written acknowledgment by CMS that the operational DMES meets all legal and operational requirements necessary for 75% federal financial participation (FFP)
CFR	Code of Federal Regulations – The federal rules that direct the state in its administration of the Medicaid program and implementation and operation of an MMIS
Change Control	Formal process for identifying, submitting, tracking, evaluating, coordinating, reviewing, and approving/disapproving proposed changes to items under configuration management.
CHIP	Children's Health Insurance Program
CHS	Contract Health Services
Claim	A request for Medicaid to pay for health care services.
Clean Claim	A claim that can be adjudicated without obtaining additional information from the provider of service or a third party; clean claims do not include claims from a provider that is under investigation for potential fraud and/or abuse or claims that routinely suspend even if due to billing errors by the provider.
CLIA	The Clinical Laboratory Improvement Amendments – Provisions of 1988 that require all laboratory testing sites to obtain either a certificate of waiver or a certificate of registration along with an identification (ID) number in order to legally perform testing anywhere in the United States
Client	Delaware uses the term "client" for participants in Delaware Medical Assistance Programs. This term is used in place of member, beneficiary, and recipient.
CMIA	Cash Management Improvement Act of 1990 (federal)
CMMI	Capability Maturity Model Integration
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COB	Close of Business
COBRA	Consolidated Omnibus Budget Reconciliation Act (federal)
Contract	The signed agreement resulting from this RFP, the chosen Contractor's Proposal and any subsequent amendments
Contract Amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract; it shall include bilateral actions, such as administrative changes, notices of termination, and notices of the exercise of a contract option

Contract Manager	The state individual responsible for providing overall project direction, acting as liaison between Contractor and Medicaid staff and monitoring Contractor performance
COTS	Commercial Off-The-Shelf
CPU	Central Processing Unit
CRDP	Chronic Renal Disease Program
D	
DAR	Deliverable Acceptance Request
Day	Calendar day, unless specified as a workday
DB2	Database 2
DCIS II	Delaware Client Information System II
DED	Data Element Dictionary
DDI	Design, Development, and Implementation
DDR	Drug Data Reporting
Deliverable	All software, documentation, reports, manuals, and any other item that the Contractor is required to produce and/or tender to the state under terms and conditions of this contract
DHCP	Delaware Healthy Children Program
DHSS	Delaware Department of Health and Social Services
Diagnosis	The classification of a disease or condition
DMAP	Delaware Medical Assistance Program
DMES	Delaware Medicaid Enterprise System
DMMA	Division of Medicaid and Medical Assistance
DMS	Division of Management Services
DMZ	Demilitarized Zone
DOE	Department of Education
DOI	Department of Insurance
DPAP	Delaware Prescription Assistance Program
DPCI	Delaware Physicians Care, Inc.
DPH	Department of Public Health
Drug Rebate	Program authorized by the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) in which drug manufacturers or labelers enter into an agreement with the Secretary, DHHS, to provide financial rebates to states based on dollar amount of their drugs reimbursed by the Medicaid program
DSAMH	Division of Substance Abuse and Mental Health
DSCYF	Department of Services for Children, Youth, and Families
DSHP	Diamond State Health Plan
DSP	Diamond State Partners
DSS	Division of Social Services
DSS	Decision Support System – Component of a data warehouse that provides analytical-level queries and reporting.
DTI	Department of Technology and Information

DUR	Drug Utilization Review – The Medicaid Drug Utilization Review (DUR) Program was created by OBRA-90. The main emphasis is to promote patient safety by an increased review and awareness of outpatient prescribed drugs. States install point-of-sale (POS) electronic claims management systems and report annually to assess how well patient safety, provider prescribing habits and dollars saved by avoidance of problems such as drug-drug interactions, drug-disease interactions, therapeutic duplication, and over-prescribing by providers
DVD-R	Digital Versatile Disk - Recordable
DW	Data Warehouse (also DW/DSS)
E	
ECMS	Electronic Claims Management Service
ECS	Electronic Claims Submission – Electronic methods of claims submission.
EDB	Enrollment Database (Medicare)
EDI	Electronic Data Interchange
EDIT	Logic within the Standard Claims Processing System (or PSC Supplemental Edit Software) that selects certain claims, evaluates or compares information on the selected claims or other accessible source, and depending on the evaluation, takes action on the claims, such as pay in full, pay in part, or suspend for manual review
EDP	Electronic Data Processing
EFT	Electronic Funds Transfer – The payment of funds made by direct deposit to a provider's bank account.
EHR	Electronic Health Record – A record of diagnoses, treatments and laboratory results stored in an electronic record for retrieval and use by authorized treatment professionals
Eligibility File	A file that maintains pertinent data for each Medicaid eligible recipient
Eligibility Verification	Refers to the process of validating whether an individual is determined to be eligible for health care coverage through the Medicaid program and/or a provider is qualified to provide services to the Medicaid population. Eligibility for the recipient and provider is determined by the State.
EMC	Electronic Media Claims
Encounter Data	Detailed data about individual health care related services provided by a capitated managed care organization (MCO) or other state-designated managed care providers. Encounter data is equivalent to a standard Medicaid claim except that it is submitted to provide service delivery data to the Agency and is not eligible for reimbursement. MCO health care related services are those covered and reimbursed by per member per month (PMPM) capitated rate payment.
EOMB	Explanation of Medical Benefits – A report of paid Medicaid claims reported to selected recipients for fraud and abuse purposes
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ERM	Enterprise Report Management
ESB	Enterprise Service Bus
ESRD	End Stage Renal Disease

Evaluation	The in-depth review and analysis of a Bidder's proposal
EVS	Eligibility Verification System
F	
FA	Fiscal Agent – Refers to the Contractor operating the DMES. A Contractor that processes Medicaid provider claims for payments and performs certain other related functions as an agent for the state.
FACTS	Family and Child Tracking System
FDA	Food and Drug Administration
FEIN	Federal Employer Identification Number
FFP	Federal Financial Participation – The percentage amount contributed by the federal government towards a category of costs in a State's Medicaid program
FFS	Fee-for-Service – A method of health care reimbursement based upon payment for specific services on a client's behalf
FFY	Federal Fiscal Year
FOIA	Freedom of Information Act
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FTE	Full-Time Employee
FTE Equivalent	Full-Time Employee Equivalent – A unit of measurement that describes the eight hours a full-time employee works in a day
G	
GAAP	Generally Accepted Accounting Principles
H	
HBM	Health Benefits Manager
HCBS	Home and Community Based Service
HCPCS	Healthcare Common Procedure Coding System – A coding system designed by CMS that describes the physician and non-physician patient services covered by Medicaid and Medicare Programs and used primarily to report reimbursable services provided to patients
HIBCC	Health Industry Business Communications Council
HIC	Health Insurance Code
HHRG	Home Health Resource Group
HIPAA	The Health Insurance Portability and Accountability Act of 1996 – A federal law that includes requirements to protect patient privacy, to protect security of electronic medical records, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers
HIPAA 270/271	HIPAA X.12 standard format eligibility verification requests and response
HIPPS	Health Insurance Prospective Payment System
HMO	Health Maintenance Organization
HPES	Hewlett Packard Enterprise Services, formerly Electronic Data Systems, LLC. (EDS) – FA to the Delaware Medicaid Enterprise
I	

ICD-9; ICD-10; ICD-10-CM	International Classification of Diseases and Related Health Problems, Ninth Revision and Tenth Revision, Clinical Modification – A classification and coding structure of diseases used by states and the health care community to describe patients' conditions and illnesses and to facilitate the collection of statistical and historical data
ICD-10-PCS	International Classification of Diseases, Tenth Revision, Procedure Coding System
ICF/MR	ICF/MR – Intermediate Care Facility for the Mentally Retarded
ICN	Individual Claim Number
ICN	Image Control Number – A unique serial number applied to each imaged document stored in DMES. Several ICNs may be associated with a single Transaction Control Number and non-claim documents may have an ICN as their sole control number.
ID	Identification
IMD	Institution for Mental Disease
IRM	Information Resource Management
IRS	Internal Revenue Service
ISAE	International Standard on Assurance Engagements – Assurance Reports on Contracts at a Service Organization
IT	INFORMATION TECHNOLOGY – Any equipment, or interconnected system(s) or subsystem(s) or equipment, that is used in the automatic acquisition, storage, manipulation, management, movement, control, display, switching, interchange, transmission, or reception of data or information by the Agency. IT includes computers, ancillary equipment, software, firmware, and similar procedures, services (including support services), and related resources
ITF	Integrated Test Facility
ITIL	Information Technology Infrastructure Library
IVR	Integrated Voice Response
IV&V	Independent Verification and Validation
J	
JAD	Joint Application Design
K	
L	
LAN	Local Area Network – Backbone and Network Servers
LEIE	List of Excluded Individuals/Entities
Lock-In	AA DMES function that a Medicaid recipient receives certain benefits from a single, identified source. Lock-in is most used in Pharmacy Benefits Management to require a potentially abusive recipient to pick up prescriptions at a certain pharmacy only. Lock-in is used in managed care to require a recipient to receive care through a certain HMO or service network for a set period of time.
LTC	Long-Term Care Medicaid Programs
M	
Managed Care	Systems of care designed to improve clients' access to health care and continuity of care, while reducing the overall costs of care. Usually

	provided through an MCO.
MAPIR	Medical Assistance Provider Incentive Repository
MAR	Management and Administrative Reporting
MBE	Minority Business Enterprise
MCI	Master Client Index
MCO	Managed Care Organization – Entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. The term generally includes HMOs, PPOs, and Point of Service plans. In the Medicaid world, other organizations may set up managed care programs to respond to Medicaid managed care. These organizations include FQHCs, integrated delivery systems, and public health clinics.
MECT	Medicaid Enterprise Certification Toolkit
Medicaid	The federal medical assistance program as described in Title XIX of the Social Security Act.
Medicare	The federal health care program as described in Title XVIII of the Social Security Act. Part A covers hospitalization and Part B covers medical insurance.
MFCU	Medicaid Fraud Control Unit – A section under the Delaware Attorney General that investigates potential Medicaid fraud and abuse.
Milestone	The measuring point used to review and approve progress, to authorize continuation of work, and, depending on the terms of the contract, to pay for work completed.
MITA	Medicaid Information Technology Architecture – An initiative by the federal CMS to modernize MMISs operated by the states by promoting greater interoperability with other systems, use of COTS software, reusable programs and systems, and system analysis that allows business needs to drive system development.
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MMIS	Medicaid Management Information System – Medicaid claims processing and information system
MML	MITA Maturity Level
Modification	A modification is when program source code must be changed to implement a system functional or performance requirement beyond the system requirements.
Module	A collection of services containing multiple distinct activities to provide a method for delivering a single service or many services. Each service within the module involves a standardized process model which may be simple or complex based on the set of rules that shape the service delivery.
MS	Microsoft
MSIS	Medicaid Statistical Information Systems
MWD	Medicaid for Workers with Disabilities
N	
Named Staff	Named Staff must be available for assignment on the DMES on a full-time equivalent basis and must be solely dedicated to this project

NCCI	National Correct Coding Initiative
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NET	Non-emergency Transportation
NF	Nursing Facility
NIST	National Institute for Standards and Technology
NPI	National Provider Identifier
NSF	Non-Sufficient Funds
O	
O&M	Operations and Maintenance (task)
OCR	Optical Character Recognition
Online	Connected to a computer or computer network.
ORT	Operational Readiness Testing
OSE	Open Servlet Engine
Overpayment	Payment made to a provider in excess of the amount allowed under the Medicaid State Plan guidelines
P	
P&T	Pharmacy & Therapeutic Committee
PA	Prior Authorization
Paid Claim	A claim that has resulted in the provider being reimbursed for some dollar amount or a zero paid amount
Part D	Medicare Prescription Drug Coverage Plans
PBM	Pharmacy Benefits Manager
PC	Personal Computer
PCP	Primary Care Physician or Primary Care Provider
PDF	Portable Document Format
PDL	Preferred Drug List
PDP	Prescription Drug Plan
PHI	Protected Health Information
PMBOK®	Project Management Body of Knowledge
PMI	Project Management Institute
PMO	Project Management Office
POS	"Point of Sale" for Pharmacy
Prime Contractor	A Contractor who contracts directly with the state for performance of the work specified in this RFP
Procurement Library	The collection of DMES documentation, provider policy manuals, and general information related to the Delaware Medicaid program and the DMES
Pro-DUR	Prospective Drug Utilization Review
PET	Proposal Evaluation Team
Provider	A person, organization, or institution that provides health care related services and is enrolled in the Delaware Medicaid program
Provider Manual	Provider manuals that contain the State's program specific coverage,

	limitation, and reimbursement policies
Q	
QA	Quality Assurance
QC	Quality Control
QI-1	Qualified Individual-1 Program
QMB	Qualified Medicare Beneficiary
QMP	Quality Management Plan
R	
RA	Remittance Advice
RBRVS	Resource-Based Relative Value Scale
Recipient	A person who has been determined to be eligible for assistance in accordance with the state plan(s) under Title XIV and Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, and/or Title IV of the immigration and Nationality Act. Delaware uses the term “client.”
Retro-DUR	Retrospective Drug Utilization Review
RFP	REQUEST FOR PROPOSAL – The document that describes to prospective proposers the requirements of the FA, DMES, terms and conditions, and technical information
ROSI	Reconciliation of State Invoice
S	
SaaS	Software as a Service
SDLC	System Development Lifecycle Concept
Service	A group of component services some of which may have component services themselves.
SLA	Service Level Agreement
SLMB	Specified Low Income Medicare Beneficiary
SME	Subject Matter Expert
SOA	Service Oriented Architecture
SOW	Statement of Work
SPI	Seriously and Persistently Ill
SQL	Structured Query Language
SS-A	State Self-Assessment
SSA	Social Security Administration – The federal organizational unit within DHHS that determines Medicaid eligibility for various federally administered programs.
SSAE	Statement on Standards for Attestation Engagements
SSL	Secure Sockets Layer
SSN	Social Security Number
SSO	Single Sign-On
Statutes	Laws passed by Congress or a state legislature and signed by the President or the Governor of a state, respectively, that are codified in volumes called “codes” according to subject matter.
Subcontractor	Any entity contracting with the Prime Contractor to perform services or

	to fulfill any of the requirements requested in this RFP or any entity that is a subsidiary of the Prime Contractor that performs the services or fulfills the requirements requested in this RFP.
SURA	Supplemental Unit Rebate Amount
SUR	Surveillance and Utilization Review Subsystem
System Documentation	Documents that contain the technical description of the configuration, components, and operation of the DMES.
T	
TPL	Third Party Liability – A situation in which a claim submitted as a result of an accident or injury where another individual or organization may be responsible for payment or in which a recipient has health insurance resources other than Medicaid or Medicare which are responsible for at least partial payment of a claim.
U	
UAT	User Acceptance Testing
UPS	Uninterruptable Power Source
UROA	Unit Rebate Offset Amount
User	Any individual or a group identified by the state as the persons authorized to use all or parts of DMES functions.
V	
Contractor	A Contractor or proposer for the DMES Contract under this RFP
VFC	Vaccines For Children
VOE	Veteran Owned Enterprise
W	
WAN	Wide Area Network – Connection between two LANs.
WBE	Women Business Enterprise
WBS	Work Breakdown Structure – A detailed plan used to complete and track a project. The WBS identifies every task in the project, estimates time and resource requirements, identifies predecessor and successor tasks, identifies the critical path, and is used to compare to actual project performance
WIP	Work In Process
Workday	A day scheduled for regular State of Delaware employees to work; Monday through Friday except holidays observed by regular State of Delaware employees. Timeframes in the RFP requiring completion with a number of workdays shall mean by 5:00 p.m. Eastern time on the last workday.
X	
XML	Extensible Markup Language – Designed to improve the functionality of the Web by providing more flexible and adaptable information identification. XML is actually a meta language (a language for describing other languages) that allows users to design their own customized markup languages for limitless different types of documents.
Y	
Z	

G ATTACHMENT G: PROCUREMENT LIBRARY

It is critical that interested Vendors carefully read, study, analyze, and understand all sections and provisions of the Request for Proposal (RFP) and reference material contained in the Medicaid Procurement Library. The selected Vendor will be required to design, develop, test, implement, and operate a replacement Delaware Medicaid Enterprise System (DMES) and provide fiscal agent (FA) services.

1. Current Delaware Medicaid Management Information System (MMIS) System Documentation.
2. Current MMIS Technical Architecture
3. Delaware Medicaid Program Statistics.
4. Delaware Medicaid Provider Enrollment Guide.
5. Delaware Medical Assistance Program (DMAP) Operations Manual.
6. DMMA Organizational Charts.
7. Current Fiscal Agent Organizational Charts.
8. Provider Manuals.
    a. Common Sections.
    b. Provider Specific Billing sections.
    c. Provider Specific Policy sections.
9. User Manuals.
    a. Business Area User Manuals.
    b. Appendices.
10. Fiscal Agent Statistics.
11. MMIS Report Listing.
12. State Medicaid Manual.
13. Centers for Medicare & Medicaid Services (CMS) Enhanced Funding Requirements: Seven Conditions and Standards Medicaid Information Technology (IT) Supplement (MITS-11-01-v1.0).
14. State Holiday Schedule.
15. List of mail pieces sent by the fiscal agent including a description and monthly/annual volumes.
16. Delaware MMIS Turnover Plan.
17. Technical Architecture Templates

H ATTACHMENT H: CURRENT MMIS TECHNICAL ARCHITECTURE

Systems Configuration

The following table summarizes configurations of all the servers used to run or support the Delaware Medicaid Management Information System (MMIS).

Platform	Model	Operating System	CPU	Memory	Physical/ Virtual	Host (if Virtual)	Disk Capacity
DSDESUN11	Sun V490	Solaris 10	2 Dual-Core UltraSPARC-IV+ 1.8 GHz	16 GB	Physical	Not Applicable	3.8 TB RAID 5
DSDESUN12	Sun V490	Solaris 10	2 Dual-Core UltraSPARC-IV+ 1.8 GHz	16 GB	Physical	Not Applicable	3.8 TB RAID 5
DSDESUN13	Sun Fire T2000	Solaris 10	1 Quad-Core UltraSPARC-T1 1 GHz	32 GB	Physical	Not Applicable	136 GB RAID 1
DSDESUN15	Sun V490	Solaris 10	2 Dual-Core UltraSPARC-IV+ 1.8 GHz	16 GB	Physical	Not Applicable	818 GB RAID 1 3.1 TB RAID 5
DSDESUN16	Sun V490	Solaris 10	2 Dual-Core UltraSPARC-IV+ 1.8 GHz	16 GB	Physical	Not Applicable	3.1 TB RAID 5
DSDESUN18	Sun Fire T2000	Solaris 10	1 Quad-Core UltraSPARC-T1 1Ghz	32 GB	Physical	Not Applicable	136 GB RAID 1
DSDETIV1	Sun Fire V245	Solaris 10	2 UltraSPARC-IIIi 1.5 GHz	8 GB	Physical	Not Applicable	146 GB RAID 1
DSDETIV2	Sun Fire V245	Solaris 10	2 UltraSPARC-IIIi 1.5 GHz	8 GB	Physical	Not Applicable	146 GB RAID 1
DSDEWAS1	Virtual Sun Server	Solaris 10	1 Quad-Core UltraSPARC-T1 1 GHz	16 GB	Virtual	DSDESUN14	136 GB RAID 1

Platform	Model	Operating System	CPU	Memory	Physical/ Virtual	Host (if Virtual)	Disk Capacity
DSDEWAS2	Virtual Sun Server	Solaris 10	1 Quad-Core UltraSPARC-T1 1 GHz	16 GB	Virtual	DSDESUN14	136 GB RAID 1
DSDEWEB1	Virtual Sun Server	Solaris 10	1 Quad-Core UltraSPARC-T1 1 GHz	2 GB	Virtual	DSDESUN13	136 GB RAID 1
DSDEWEB2	Virtual Sun Server	Solaris 10	1 Quad-Core UltraSPARC-T1 1 GHz	2 GB	Virtual	DSDESUN13	136 GB RAID 1
USIDSID002	Virtual ESX Server	Windows 2008	1 Virtual CPU	2 GB	Virtual	USIDSVMW008	100 GB
USIDSVMW008	HP Proliant DL 380 G7	VMWare ESX 4.1	4 CPUs x 2.132 GHz	18 GB	Physical	Not Applicable	3.8 TB RAID 5
USNEDXIX02	Virtual ESX Server	Windows 2003 Server	1 Virtual CPU 2.99 GHz	3.75 GB	Virtual	USNESVMW002	925 GB RAID5
USNEDXIX03	Dell PowerEdge 2850	Windows 2003 Server SP2	2 Intel Xeon 3.4 GHz	2 GB	Physical	Not Applicable	124 GB RAID 5
USNEDXIX05	Virtual ESX Server	Windows 2003 Server	1 Virtual CPU 2.66 GHz	1 GB	Virtual	USIDSVMW001	40 GB RAID 5
USNEDXIX06	Dell PowerEdge 2600	Windows 2003 Server SP2	2 Intel Xeon 2.4 GHz	2 GB	Physical	Not Applicable	119 GB RAID 5
USNESBOJ005	Virtual ESX Server	Windows 2003 Server SP2	1 Virtual CPU 3.00 GHz	2 GB	Virtual	USNESVMW002	44 GB RAID 5
USNESBOJ009	Virtual ESX Server	Windows 2003 Server SP2	1 Virtual CPU 3.00 GHZ	3.75 GB	Virtual	USNESVMW002	150 GB RAID 5
USNESHD012	Virtual ESX Server	Windows 2003 Server SP2	1 Virtual CPU 3.00 GHz	2 GB	Virtual	USNESVMW002	30 GB RAID 5

Platform	Model	Operating System	CPU	Memory	Physical/ Virtual	Host (if Virtual)	Disk Capacity
USNESMIT01	Virtual ESX Server	Windows 2003 Server	2 Virtual CPU 3.00 GHz	2 GB	Virtual	USNESVMW002	100 GB RAID 5
USNESMIT02	Virtual ESX Server	Windows 2003 Server SP2	2 Virtual CPU 2.66 GHz	2 GB	Virtual	USIDSVMW001	100 GB RAID 5
USNESSQUID05	Virtual ESX Server	Windows 2003 Server SP2	1 Virtual CPU 3.00 GHz	1 GB	Virtual	USNESVMW002	30 GB RAID 5
USNESSTG01	Dell PowerVault DP600	Windows Storage Server 2003R2	8 Intel Xeon 2.4 GHz	32 GB	Physical	Not Applicable	6 TB RAID 5
USNESTEST001	Dell PowerEdge 2600	Windows 2000 Server SP2	2 Intel Xeon 2.4 GHz	2 GB	Physical	Not Applicable	119 GB RAID 5
USNESXIX002	Virtual ESX Server	Windows 2003 R2	1 Virtual PCU	4 GB	Virtual	USNESVMW007	749 GB RAID 5
USNETXIX004	Virtual ESX Server	Windows 2008 Server	1 Virtual CPU 2.13 GHz	3 GB	Virtual	Not Applicable	347 GB RAID 1
USNESVMW007	HP Proliant DL 380 G7	VM Ware ESX 4.1	4 CPUs x 2.132 GHz	18 GB	Physical	Not Applicable	3.8 TB RAID 5
USNESFAX004	HP Proliant DL 380 G6	Windows 2003 Server SP2	4 CPUs x 2.132 GHz	4 GB	Physical	Not Applicable	200 GB RAID 5
USNEDXIX07	HP Proliant DL 120 G6	Windows 2008 R2	2 CPUs x 2.40 GHz	2 GB	Physical	Not Applicable	150 GB RAID 5
USNESDHCP001	Virtual ESX Server	Windows 2008 R2	1 Virtual CPU	4 GB	Virtual	USNESVMW007	44 GB
USNESSTG02	HP Proliant DL 380 G5 Storage	Windows 2003 Storage Server SP2	8 CPUs x 2.67 GHZ	32 GB	Physical	Not Applicable	3.5 TB RAID 5

Server and Systems Functions

DSDESUN11

DSDESUN11 is a physical server that is the primary development server for the Delaware MMIS. It is run out of the Newark, Delaware HPES site.

DSDESUN12

DSDESUN12 is a physical server that is the Model Office server for the Delaware MMIS. It is run out of the Newark, Delaware HPES site.

DSDESUN13

DSDESUN13 is a physical server that houses virtual Solaris servers using logical domains. It is run out of the Newark, Delaware HPES site.

DSDESUN15

DSDESUN15 is a physical server that serves as the production server for the Delaware MMIS. It also houses the Point of Sale system. It is run out of the Indianapolis, Indiana HPES site.

DSDESUN16

DSDESUN16 is a physical server that houses the MAR, SUR, and Ad Hoc databases. It is run out of the Indianapolis, Indiana HPES site.

DSDESUN18

DSDESUN18 is a physical server that houses virtual Solaris servers using logical domains. It is run out of the Indianapolis, Indiana HPES site.

DSDETIV1

DSDETIV1 is a physical server that houses Tivoli Storage Manager 5.5, which is used to back up all of the systems at the HP Indiana site. It is run out of the Indianapolis, Indiana HPES site.

DSDETIV2

DSDETIV2 is a physical server that houses Tivoli Storage Manager 5.5, which is used to back up all of the systems at the HP Delaware site. It is run out of the Newark, Delaware HPES site.

DSDEWAS1

DSDEWAS1 is a virtual server that houses WebSphere Application Server 6.1, which is used to provide the production web application environment for the site of www.dmap.state.de.us. It works in tandem with the production web server, DSDEWEB1. This server's network connectivity resides in the Application DMZ in Indianapolis. It is run out of the Indianapolis, Indiana HPES site.

DSDEWAS2

DSDEWAS2 is a virtual server that houses WebSphere Application Server 6.1, which is used to provide the model web application environment for the site of dmapm.state.de.us. It works in tandem with the model web server, DSDEWEB2. This server's network connectivity resides in the Application DMZ in Newark. It is run out of the Newark, Delaware HPES site.

DSDEWEB1

DSDEWEB1 is a virtual server that houses IBM HTTPD Web Server, which is used to provide web content to users of the sites of www.dmap.state.de.us. It works in tandem with the production web application server, DSDEWAS1. This server's network connectivity resides in the Web DMZ in Indianapolis. It is run out of the Indianapolis, Indiana HPES site.

DSDEWEB2

DSDEWEB2 is a virtual server that houses IBM HTTPD Web Server, which is used to provide web content to users of the sites of dmapm.state.de.us. It works in tandem with the model web application server, DSDEWAS2. This server's network connectivity resides in the Web DMZ in Newark. It is run out of the Newark, Delaware HPES site.

USIDSVMW008

USIDSVMW008 is a physical server that runs VMWare ESX 4.1, allowing the server to run virtual servers. It is run out of the Indianapolis, Indiana HPES site.

USNEDXIX02

USNEDXIX02 is a virtual server that serves as the main file server for the HPES-Delaware site. It is run out of the Newark, Delaware HPES site.

USNEDXIX03

USNEDXIX03 is a physical server that serves as a domain controller, DNS server, and a terminal server licensing server. It is run out of the Newark, Delaware HPES site.

USNEDXIX05

USNEDXIX05 is a physical server that serves as a domain controller and a DNS server. It is run out of the Indianapolis, Indiana HPES site.

USNEDXIX06

USNEDXIX06 is a physical server that serves as a domain controller, DNS server, and DHCP server. It is run out of the Newark, Delaware HPES site.

USNESBOJ005

USNESBOJ005 is a virtual server that houses the model Business Objects XI application used to query the HPES Ad Hoc Database. It is run out of the Newark, Delaware HPES site. It works in tandem with Ad Hoc database on DSDESUN16.

USNESBOJ009

USNESBOJ009 is a virtual server that houses the production Business Objects XI application used to query the HPES Ad Hoc Database. It is run out of the Newark, Delaware HPES site. It works in tandem with Ad Hoc database on DSDESUN16.

USNESFAX004

USNESFAX004 is a virtual server that houses the Delaware MMIS Documentation website, which is used to allow State users access to MMIS documentation, and also houses our Fax Server Software, Accuroute. It is run out of the Newark, Delaware HPES site.

USNESHD012

USNESHD012 is a virtual server that houses the production Delaware MMIS Help Desk Ticketing System. It is run out of the Newark, Delaware HPES site.

USNESMIT01

USNESMIT01 is a virtual server that houses the model MoveIt File Transfer Site at www.edsdocumentmodel.com, which is used to allow transfer of files between HPES and drug manufacturers in order to collect drug rebate dollars due to the State of Delaware. This server's network connectivity resides in the Web DMZ in Newark. It is run out of the Newark, Delaware HPES site. It is run out of the Indianapolis, Indiana HPES site.

USNESMIT02

USNESMIT01 is a virtual server that houses the model MoveIt File Transfer Site at www.edsdocumenttransfer.com, which is used to allow transfer of files between HPES and drug manufacturers in order to collect drug rebate dollars due to the State of Delaware. This server's network connectivity resides in the Web DMZ in Indianapolis.

USNESSQUID05

USNESSQUID05 is a virtual server that runs the SQUID proxy server 2.7, providing web proxying services for our users as they traverse the internet. It is run out of the Newark, Delaware HPES site.

USNESSTG01

USNESSTG01 is a physical server that serves as a Network Attached Storage Device. It is run out of the Newark, Delaware HPES site.

USNESTEST001

USNESTEST001 is a physical server that houses the test environment for the Delaware Windows Based Network. It is run out of the Newark, Delaware HPES site.

USNESXIX002

USNESXIX002 is a virtual server that houses the Delaware MMIS Reports Retrieval System, commonly referred to as Computer Output to Laser Disk (COLD). COLD is run by IBM's Content Manager On Demand. It is run out of the Newark, Delaware HPES site.

USNETXIX004

USNETXIX004 is a virtual server that serves as the HPES terminal server, which is used to test the MMIS application in a multi-user environment, similar to the State's terminal servers used to deploy the MMIS application to State users. It is run out of the Newark, Delaware HPES site.

USNESVMW007

USNESVMW007 is a physical server that runs VMWare ESX 4.1, allowing the server to run virtual servers. It is run out of the Newark, Delaware HPES site.

USNEDXIX07

USNESTEST010 is a physical server that houses the virtual backup software Veeam for the Delaware Windows Based Network. It is run out of the Newark, Delaware HPES site.

USNESDHCP001

USNESDHCP001 is a physical server that runs a DHCP server for the BPO Phone System. It also houses the Syslog-NG logging utility. It is run out of the Newark, Delaware HPES site.

USNESSTG02

USNESSTG02 is a physical server that serves as a Network Attached Storage Device. It is run out of the Indianapolis, Indiana HPES site.

USNESVMW008

USNESVMW008 is a physical server that runs VMWare ESX 4.1, allowing the server to run virtual servers. It is run out of the Indianapolis, Indiana HPES site.

USIDSID002

USIDSID002 is a virtual server that serves as the HPES terminal server. It is run out of the Indianapolis, Indiana HPES site.

USNESCCK003

USNESCCK03 is a virtual server that serves as the Claim Check processing server. It is run out of the Indianapolis, Indiana HPES site.

Network Configuration

Narrative

HP Enterprise Services (HPES) manages computer systems and networks located at multiple locations in support of the Delaware MMIS.

The primary computer processing hardware used to support the MMIS is located at the HPES Indiana Data Center in Indianapolis, Indiana. Since this site also houses the MMIS run for the State of Indiana by HPES, all servers, databases, and processing for the Delaware MMIS is segregated from the Indiana MMIS through the use of separate sub networks and firewalls. The systems administrators at this site deliver support for installation, modification, tuning, and monitoring of all main server hardware and software. In addition, computer operators monitor batch cycles, backup processes, and support for file recovery 24 hours per day. Indiana houses the servers used for the production and ad hoc query support of the Delaware MMIS. It houses communications equipment used to connect to the HPES Health Network Cloud (HNC, formerly referred to as the Shared Medicaid Network), Business Exchange Services (BES), the Delaware Healthcare Services site, and the internet. The HNC is a managed, routed, Layer 3, Multiprotocol Label Switching (MPLS) wide area network used by HPES to deliver services to its State and Local Government Healthcare contracts. The HNC allows states to use leveraged resources between healthcare sites much easier than using HP Global Secure Network (GSN). Network traffic across the HNC is encrypted at each sites firewall via an IPSEC tunnel. All end points on the HNC also have active Intrusion Prevention Scanning on the network segments for that site. Firewalls are also used for the creation of a demilitarized zone (DMZ) for the four internet facing websites run out of the Indiana site listed below:

- www.dmap.state.de.us
- https://mapirpub.dhss.delaware.gov
- https://mapiradm.dhss.delaware.gov
- www.edsdocumenttransfer.com

HPES uses the Delaware Healthcare Services site located in Newark, Delaware as the primary operational and development site for the MMIS. It houses staff, systems, and equipment used to support multiple operational aspects of the MMIS. These include mailroom, call center, systems development, systems administration, technical help desk, business support, and management functions. Systems on site are used for MMIS development, testing, disaster recovery, file and print services, paper claims input, report/output collection, medical case management, call center, and ad hoc query presentation. This site houses connections to the State of Delaware, the HP Global Secure Network (GSN), the HNC, the Indiana Processing Center, and the Internet. The connection to the State of Delaware is the communications used for the State of Delaware to gain access to the MMIS. GSN is a managed network used to connect to HP corporate resources. The HNC is a managed, routed, Layer 3, Multiprotocol Label Switching (MPLS) wide area network used by HPES to deliver services to its State and Local Government Healthcare contracts. The HNC allows states to use leveraged resources between healthcare sites much easier than using HP Global Secure Network (GSN). Network traffic across the HNC is encrypted at each sites firewall via an IPSEC tunnel. All end

points on the HNC also have active Intrusion Prevention Scanning on the network segments for that site. Firewalls are also used for the creation of a demilitarized zone (DMZ) for the four internet facing websites run out of the Newark site listed below:

- www.dmap.state.de.us
- https://mmapirpub.dhss.delaware.gov
- https://mmapiradm.dhss.delaware.gov
- www.edsdocumentmodel.com

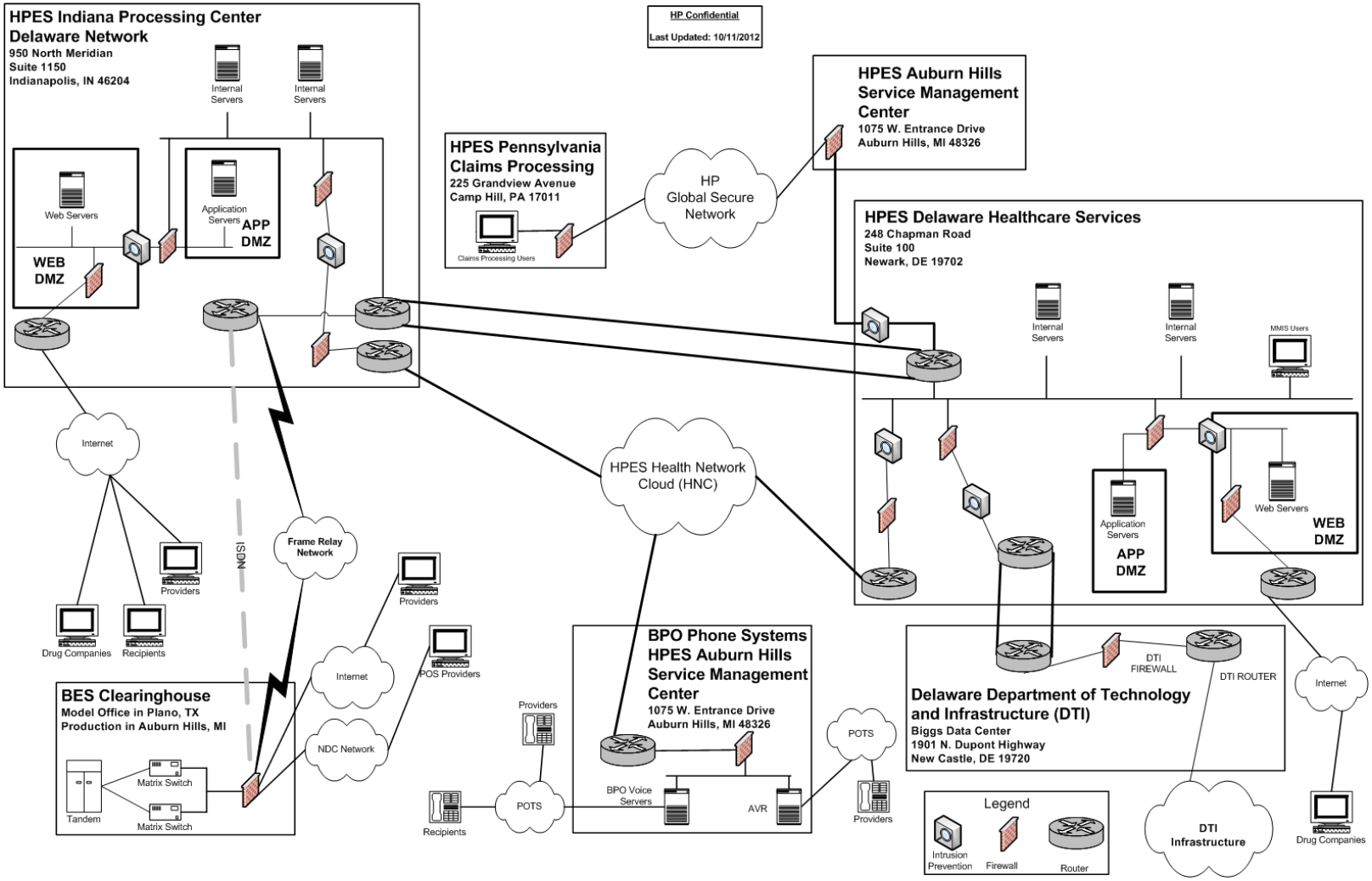
HP Business Exchange Services allows for business-to-business services that facilitates the electronic transmission of batched health care claims via the internet and for Point of Sale pharmacy health care claims. BES production processing is located at the Auburn Hills Service Management Center (SMC) located in Auburn Hills, Michigan. BES model/disaster processing is located at the Plano SMC in Plano, Texas.

The HPES Pennsylvania Claims Processing team is located at the HPES site in Camp Hill, PA. This team connects to the Delaware MMIS thru GSN and is responsible for the approval or denial of pending health care claims in the MMIS.

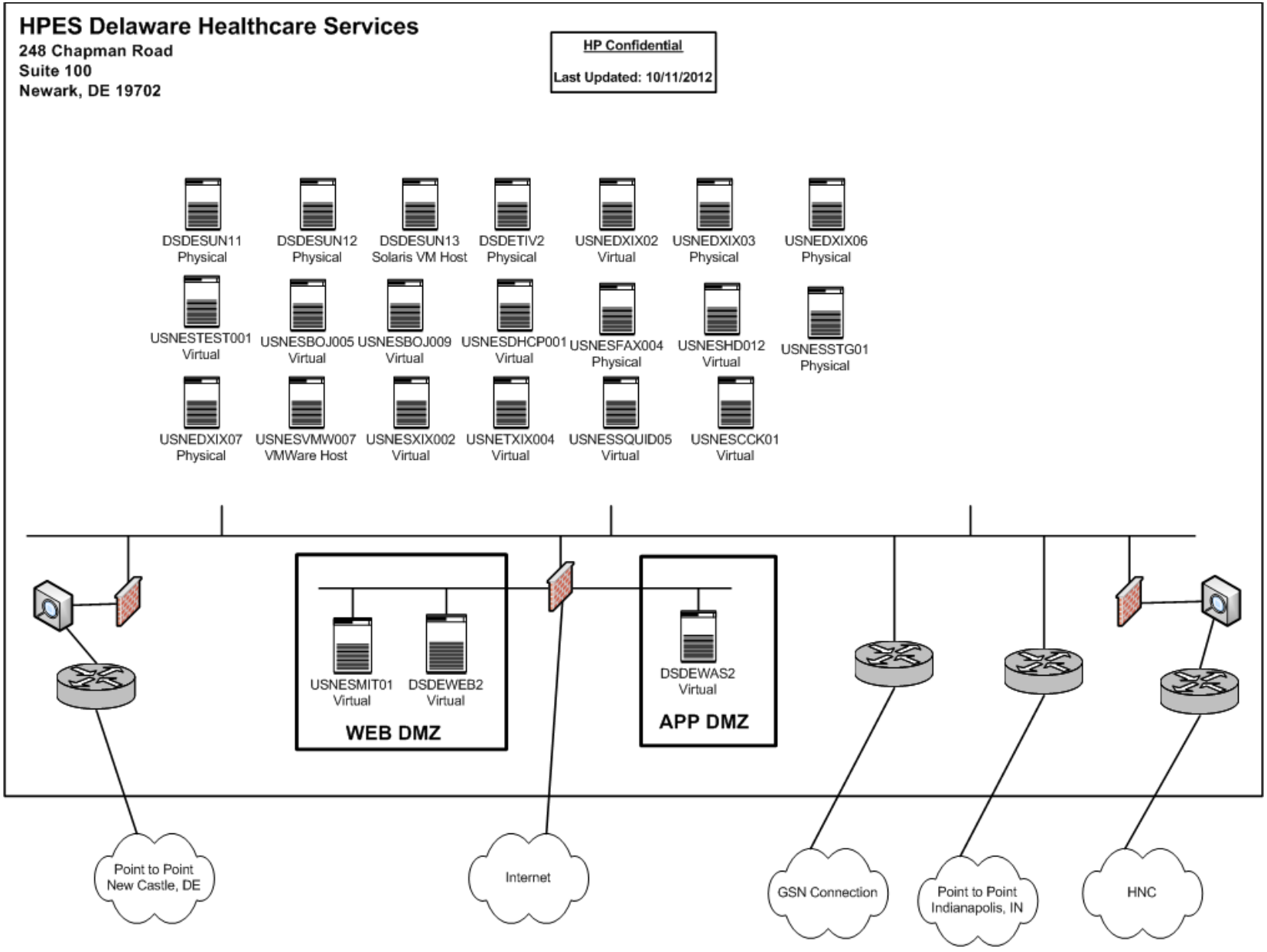
The HPES Business Process Outsourcing (BPO) Voice Systems are located in Auburn Hills, MI. These Private Branch Exchanges allow for the management of all telephone calls into and out of the HPES Delaware Healthcare Services site in Newark, DE. This site also provides Automated Voice Response (AVR) Service for the HPES Delaware Healthcare Services account.

The HPES Platform Team, consisting of systems and database administrators, is responsible for set up and ongoing maintenance for locally controlled assets. The Platform team is also responsible for and communications with any HP corporate resources that have management of routers, firewalls, and other networking hardware.

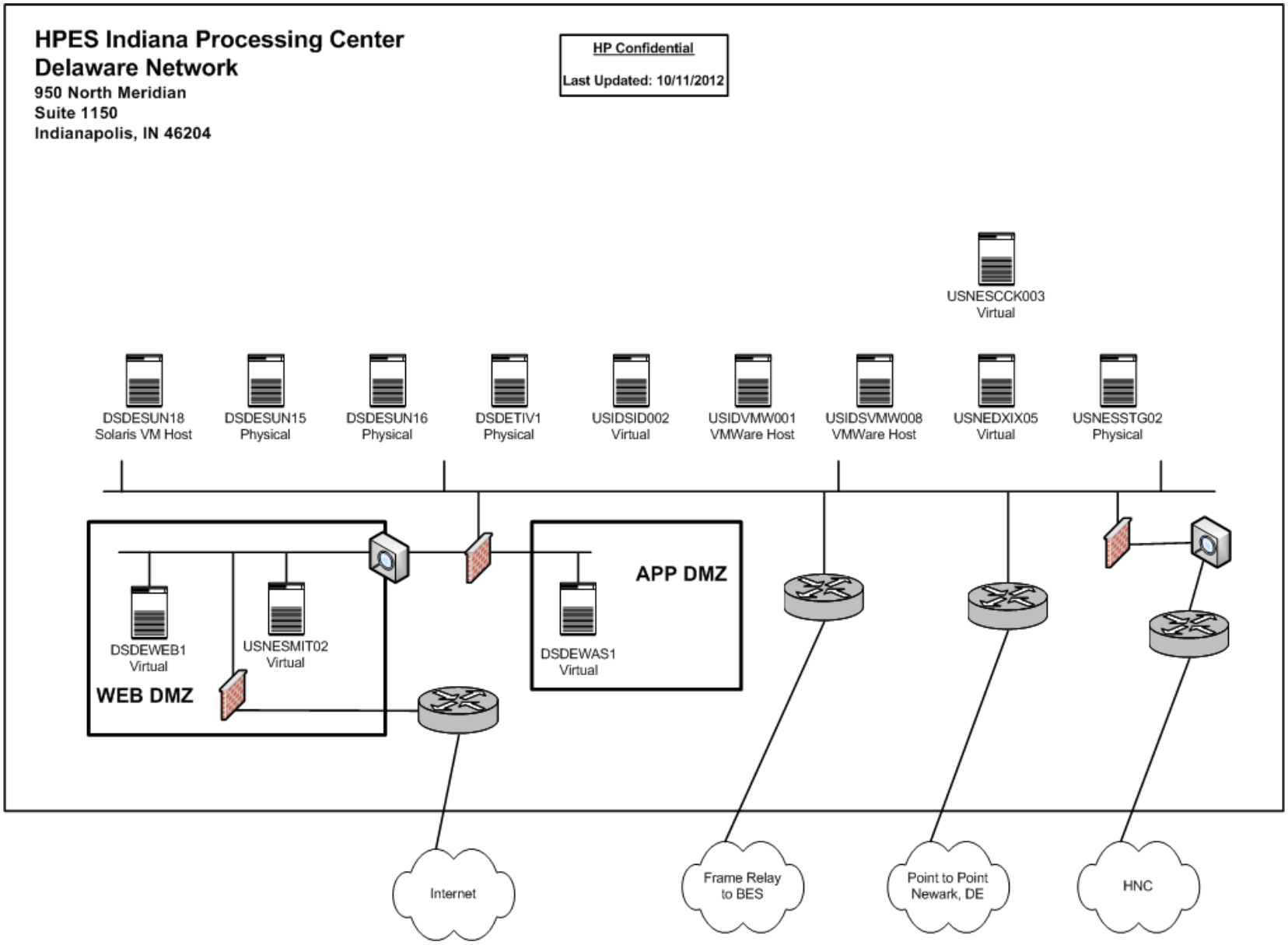
Network Configuration Diagram



Newark, Delaware HPES Site Configuration



Indianapolis, Indiana HPES Site Configuration



DMAP Web Configuration

The configuration of the Delaware Medical Assistance Program (DMAP) website, at www.dmap.state.de.us, consists of four major components:

- IBM WebSphere Application Server
- IBM HTTPD Web Server
- Socket Listener Server
- Eligibility Tuxedo Service

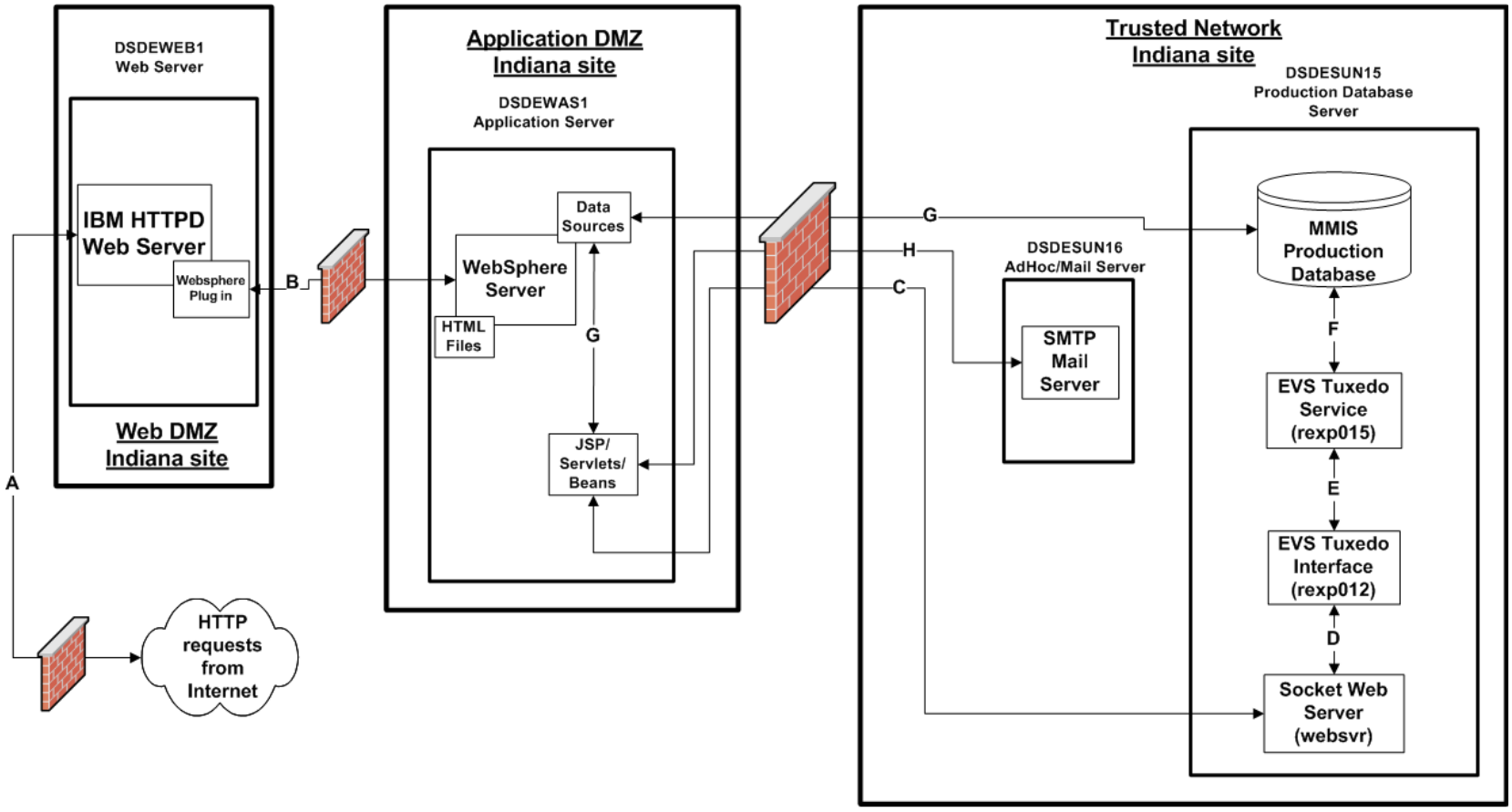
The DMAP web solution is a three tiered web application that consists of a web/presentation layer, an application layer, and a database layer. Each layer/function exists in a unique DMZ, which houses other servers with like functions. The DMAP web solution uses an Open Servlet Engine (OSE) Remote configuration to process all web transactions, whether static pages or dynamic/interactive content. The production IBM HTTPD Web Server runs on DSDEWEB1 and resides in the Web DMZ. It communicates with the production WebSphere Application Server, run on DSDEWAS1, which resides in the application DMZ. DSDEWEB1 communicates with DSDEWAS1, which resides on the trusted network, through the use of a WebSphere plug-in and via TCP/IP ports that are known to the firewall that segregates the DMZ from the trusted network.

The IBM HTTPD Web Server is responsible for passing the HTTP requests to WebSphere and passing back the response to the user's browser. The HTTPD server also supports HTTPS requests and decrypts/encrypts data sent and received over this protocol. When user's access client or payment related transaction of the interactive DMAP website, the user is required to authenticate. All authentication information such as user ID, encrypted password, email contact, and Challenge/Response questions used for resetting passwords are stored on the production MMIS database. To use these transactions, the person's ID must be tied to a National Provider Identifier (NPI) and Taxonomy pair. This is done by a Master User of the NPI/Taxonomy pair. The Master User of the NPI/Taxonomy pair is defined as the person who has enrolled the NPI/taxonomy pair with DMAP. For more details on authentication policies, please refer to section 3.4 of the Electronic Verification System volume of the MMIS Systems Manual.

WebSphere communicates all authentication and certain interactive transactions to a Socket Listener Service running on the production server DSDESUN15. The Socket Listener Server is a C program that receives and responds with Tuxedo services transaction data. The Socket Listener Server is used by the interactive services that rely on the Eligibility Tuxedo Services for their data. The Eligibility Tuxedo Services are the services used to get check-write, client eligibility, and claim status data. These Tuxedo services are shared with the VRS.

In addition, other transactions require WebSphere to communicate directly to the MMIS production database, DEXIXP1 that resides on the DSDESUN15 server. The connections are made through the use of a secure data source defined in the WebSphere application server. These connections are pooled by WebSphere and allow the DMAP application to query and update the database. An example of this is the Provider Disclosure screen that allows providers to enter and view their yearly disclosure statement. The following is a Topology diagram of how the system is designed, followed by a narrative that helps describe the different components.

DMAP Production Topography Diagram



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Last Updated: 10/11/2012

Description of Topology Diagram

A	Web Browsers interact with the Web Server on DSDEWEB1 via HTTP and the secured HTTPS protocols. The site's URL is www.dmap.state.de.us and is only accessible from the Public Internet. The Web Server Manager is IBM's HTTPD, which is IBM's customized version of Apache.
B	The Web Server communicates with WebSphere via a plug-in. The Web server, DSDEWEB1, resides in the web DMZ and communicates with DSDEWAS1, the production WebSphere Application Server, through specific TCP/IP ports opened on the backend firewall. These ports are used by the WebSphere plug-in. In order for the plug-in to work, we employ an OSE Remote configuration where WebSphere is installed on DSDEWEB1, but is never actually started on DSDEWEB1. This allows for the Web server to access the plug-in programs and configuration data from this WebSphere installation, without having all of WebSphere's functionality turned on.
C	The site's interactive transactions that use Tuxedo Services communicate via a TCP/IP socket from the Java code on DSDEWAS1 to a C program (websvr) running on the database server, DSDESUN15. These socket transactions pass through the backend firewall. When a request is submitted by the user, a socket connection is opened to the websvr program and the transaction string of data is sent by the Java code and the websvr code send a response transaction back. The response transaction string is parsed by the Java code and the data is used to build the response Web page.
D	The Socket Listener program (websrv) forks off program rexp012 and passes it the transaction string sent from the Java code running in WebSphere. The rexp012 program is used by both VRS and the Web interactive transactions.
E	The rexp012 program takes in a command line parameter and then formats a Tuxedo transaction and calls the Tuxedo service rexp015 program.
F	The rexp015 program performs all the database access and returns the response data to rexp012. The rexp012 program responds back to the websvr program, and the websvr program responds back to the Java code. The Java code then completes the response Web page and a passes this to IBM HTTPD, which serves the page to the website guest.
G	Prior Authorization and NDC Lookups do not use the Socket process to get their data. Instead, the Java code runs Dynamic SQL directly against the production database on DSDESUN15, after the network packets are inspected by the backend firewall. WebSphere uses database data sources, which allows the reuse of the same connection for different requests. This significantly improves database requests response times.
H	The "Inquiry" link from the website brings up a Web page used by providers to send requests to the Provider Relations team. The Inquiry Web page is submitted to a Java program, which formats an email and connects to an SMTP Mail Server within the HPES infrastructure. The SMTP mail server then sends the mail to a mailbox monitored by the HPES Provider Relations team.

MOVEit Web Configuration

The Web configuration for the Delaware Drug Rebate Transfer website at www.edsdocumenttransfer.com consists of the Windows server USNESMIT01 running the following:

- Microsoft Internet Information System
- Ipswitch MOVEit DMZ

The production Delaware Drug Rebate File Transfer System is a website that allows pharmaceutical manufacturers to easily download drug claim utilization data. Their analysis of this data, allows HPES to recoup drug rebate monies owed to the State of Delaware rapidly. The site's driving engine is Ipswitch's MOVEit DMZ software suite. This suite allows for downloading of files via multiple protocols, HTTPS, SFTP, and FTP/SSL. Authentication is handled through the built-in MySQL database packaged within MOVEIT, which resides on USNESMIT01. Authentication methods allowed are either through a User ID/Password or by the use of an RSA/DSA security key provided to an HPES systems administrator by the drug manufacturer. Authorization to access to the website is granted by HPES Drug Rebate staff after they have received all necessary paperwork and contractual agreements with drug manufacturer staff. The production server, DSDESUN15, is allowed to connect to USNESMIT01 through the firewall into the DMZ via SSH. This allows DSDESUN15 to place drug rebate files onto the MOVEit site as needed. All data marked to be picked up by drug manufacturers is encrypted while the data is at rest on the MOVEit server.

System Software

The System Software section describes the major software programs used to develop and operate the Delaware MMIS.

Database and Tools

BusinessObjects

BusinessObjects XI is a powerful Ad Hoc query tool that enables users to access and analyze information. The BusinessObjects/Ad Hoc repository is installed on Sun16 and has been customized to allow for HPES and DHSS staff to quickly and easily query the Ad Hoc database through the BusinessObjects Client. BusinessObjects also has a report-scheduling feature, Broadcast Agent Server that is installed on USNESBOJ009. The Model BusinessObjects server is USNESBOJ005.

IBM DB2

IBM's DB2 UDB is the primary Relational Database Management System (RDBMS) used to support the Delaware MMIS. DB2 version 9.5 fixpack 4a is installed on all of the DSDESUN servers. DB2 version 9.5 is installed on USNESXIX002.

IBM DB2 Tools

The tools used to monitor IBM DB2 consist of the DB2 Control Center, Command Center, and the Client Configuration Assistant. DB2 Control Center is used for database maintenance tasks across all the Unix boxes. The Command Center is a tool for running SQL statements from the Windows desktop. The Client Configuration Assistant is used to configure the DB2 ODBC drivers on a PC. These are installed on a Windows platform. We are running version 9.5 fixpack 4a for each of these products.

BEA Tuxedo Services

BEA Tuxedo Services is an inter-process communications API providing the framework for the Claims processing engine. Tuxedo facilitates the development/maintenance of the claims system by offering an infrastructure (canned routines and methodologies) conducive to the client-server environment and by providing tools to monitor the claims and eligibility transactions occurring real-time.

System Management Applications

CA-Unicenter

CA-Unicenter is an enterprise management system utilized for its strong job scheduling and event management capabilities. Unix job scripts created by the SE team are primarily scheduled through the Unicenter Job Scheduler, which offers a great amount of flexibility for how and when a job can be scheduled. The event management interface allows the real-time capturing/reporting (by beeper) of events such as abended jobs and failed disks, which facilitates a quick response from the responsible party. CA-Unicenter is installed on DSDESUN11, DSDESUN12, DSDESUN15, and DSDESUN16.

Development Languages and Tools

Micro Focus COBOL

Micro Focus COBOL is COBOL for a Unix code compiler. The tool creates application program executables from COBOL source code. COBOL is used for many reports and transactions in the batch cycle. COBOL is installed on DSDESUN11, DSDESUN12, DSDESUN15, and DSDESUN16.

Studio 11

Studio 11 is the Solaris Programming Suite that includes the C programming language. C is a C compiler for Unix code. The tool creates application program executables from C source code. C is used throughout much of the claims processing engine. Studio 11 installed on UNIX servers.

Operating Systems and Utilities

Content Manager On Demand

IBM's Content Manager On Demand is a report archival system that allows for the electronic storage and retrieval of reports. Content Manager On Demand has a Web-enablement kit which allows reports and claims image retrieval through a Web browser. Currently, we are running version 8.1.4 on server USNESXIX002.

VMWare ESX

VMWare's ESX 4.1 is an enterprise level virtualization product that allows a physical server to run multiple virtual servers.

HTTPD

Apache2 HTTPD is the standard build on the Solaris 10 distribution. It is used to allow connectivity to the MAPIR applications both on the internal website, and the Internet website. Apache2 is being used on DSDEWAS1, DSDEWAS2, DSDEWEB1, and DSDEWEB2.

IBM's HTTPD is IBM's customized version of the Apache Web server. It is used to communicate and manage all http and https requests through our public Internet website. HTTPD is installed on DSDEWAS1, DSDEWAS2, DSDEWEB1, and DSDEWEB2.

Internet Information Services

Microsoft' Internet Information Services (IIS) is a Web server manager that is used to communicate and manage all http and https requests to our internal websites. IIS is installed on multiple Windows servers.

(Opt Tech Data Processing) Opt-Tech Sort

Opt-Tech Sort is a utility made by Opt-Tech that is used to sort the output created from a batch process. Opt-Tech Sort is installed on DSDESUN11, DSDESUN12, DSDESUN15, and DSDESUN16.

Solaris 10

Solaris 10 is a multi-user UNIX based Network Operating System made by Sun Microsystems. Solaris 10 is installed on and runs all of the DSDE* servers.

Tivoli Storage Manager

IBM's Tivoli Storage Manager (TSM) is backup software that is used to backup all of our servers, and if necessary, recover data to these servers. TSM 5.5 is installed on DSDETIV1 and DSDETIV2.

Unicenter Service Desk

Computer Associates' Unicenter Service Desk is a comprehensive service desk solution used to track reported user issues and their resolution. Unicenter Service Desk has a Web kit which allows users to open, view, and track their help desk issues through a Web browser. Currently, we are running version 11.2 on server USNESHD012.

WebSphere

IBM's WebSphere is used as a Web application server. Specifically, it serves up all of the content that IBM's HTTPD transmits to the end user. Plus, it controls the launching and running of all Java scripts that interface with Tuxedo and the production database when providing interactive services through the public Internet. WebSphere version 6.1 is installed on DSDEWAS1 for production and DSDEWAS2 for model.

JBoss

JBoss is used as a Web application server. Specifically, it serves up all of the content that MAPIR, through Apache2, transmits to the end user. JBoss is installed on DSDEWAS1 for production and DSDEWAS2 for model.

Windows Server 2003 and Windows Server 2008

Windows Server 2003 and Windows Server 2008 are multi-user Windows based Network Operating System made by Microsoft. A version of either Windows Server 2003 or Windows Server 2008 are installed on and run all of the Windows based servers.

System Communications

Connect Direct

Sterling Commerce's Connect Direct is a data transmission tool that is used to transmit files from the State's mainframe system to our UNIX servers. Connect Direct provides superior transmission options than an FTP server due to its error checking controls and its ability to encrypt data streams with a snap-in module. Connect Direct for UNIX version 3.8 is installed on DSDESUN15.

Accuroute

Accuroute is a desktop faxing solution manufactured by Omtool. Version 3.4 is installed on USNESFAX004.

MOVEit DMZ

MOVEit DMZ is a file transfer server that allows for transmission of files over various protocols, including HTTPS, SFTP, and FTP/SSL. It is used as the driving engine for the Delaware Drug Rebate Transfer site at www.edsdocumenttransfer.com. Version 7.0 is installed on USNESMIT01 for production and USNESMIT02 for model.

Squid

Squid is an open source proxy server that is licensed under the GNU General Public License. Squid is used to inspect websites and cache visited websites, which can improve bandwidth usage, as HPES users access the internet. Squid 2.7 is installed on USNESSQUID005.

Syslog-ng

Syslog-ng is an open source proxy server that is licensed under the GNU General Public License. Syslog-ng is used to collect Syslog entries from all managed network equipment at the Newark and Indianapolis sites. Syslog-ng is installed on USNESDHCP001.

Inbound Internet Firewall Rules

The following TCP/UDP ports are allowed to enter the Indiana DMZ from the internet:

Source	Destination	Port(s)	Comment
Any	www.dmap.state.de.us	TCP/80 TCP/443	HTTP and HTTPS
Any	https://mapirpub.dhss.delaware.gov https://mapiradm.dhss.delaware.gov	TCP/443	HTTPS
Any	www.edsdocumenttransfer.com	TCP/443 TCP/10022	HTTPS for file transfer SFTP for file transfer

The following TCP/UDP ports are allowed to enter the Indiana application DMZ from the Indiana web DMZ:

Source	Destination	Port(s)	Comment
DSDEWEB1	DSDEWAS1	TCP/81 TCP/8009 TCP/9082 TCP/9083 TCP/9084 TCP/9443 TCP/9444 TCP/9445 TCP/9446 TCP/9447 TCP/9448	Ports used for www.dmap.state.de.us https://mapirpub.dhss.delaware.gov https://mapiradm.dhss.delaware.gov websites

The following TCP/UDP ports are allowed to enter the Indiana trusted network from the Indiana application DMZ:

Source	Destination	Port(s)	Comment
DSDEWAS1	DSDESUN15	TCP/6600 TCP/50000	Ports used for: www.dmap.state.de.us, https://mapirpub.dhss.delaware.gov, and https://mapiradm.dhss.delaware.gov websites
DSDEWAS1	DSDESUN16	TCP/25	Port used for: www.dmap.state.de.us, https://mapirpub.dhss.delaware.gov, and https://mapiradm.dhss.delaware.gov websites
DSDEWAS1	DSDESUN16	UDP/123	NTP for time synchronization

The following TCP/UDP ports are allowed to enter the Indiana trusted network from the Indiana web DMZ:

Source	Destination	Port(s)	Comment
DSDEWEB1 USNESMIT02	DSDESUN16	UDP/123	NTP for time synchronization

The following TCP/UDP ports are allowed to enter the Newark web DMZ from the Internet:

Source	Destination	Port(s)	Comment
Any	www.dmapm.state.de.us	TCP/80 TCP/443	HTTP and HTTPS
Any	https://mmapirpub.dhss.delaware.gov https://mmapiradm.dhss.delaware.gov	TCP/443	HTTPS
Any	https://www.edsdocumentmodel.com/	TCP/443 TCP/10022	HTTPS for file transfer SFTP for file transfer

The following TCP/UDP ports are allowed to enter the Newark application DMZ from the Newark web DMZ:

Source	Destination	Port(s)	Comment
DSDEWEB2	DSDEWAS2	TCP/81 TCP/8009 TCP/9082 TCP/9083 TCP/9084 TCP/9443 TCP/9444 TCP/9445 TCP/9446 TCP/9447 TCP/9448	Ports used for: www.dmap.state.de.us https://mapirpub.dhss.delaware.gov https://mapiradm.dhss.delaware.gov websites

The following TCP/UDP ports are allowed to enter the Newark trusted network from the Newark application DMZ:

Source	Destination	Port(s)	Comment
DSDEWAS2	DSDESUN12	TCP/25 TCP/6620 TCP/50001	Ports used for: www.dmap.state.de.us, https://mapirpub.dhss.delaware.gov, and https://mapiradm.dhss.delaware.gov websites
DSDEWAS2	DSDESUN12	UDP/123	NTP for time synchronization

The following TCP/UDP ports are allowed to enter the Newark trusted network from the Newark web DMZ:

Source	Destination	Port(s)	Comment
DSDEWEB1 USNESMIT01	DEDESUN16	UDP/123	NTP for time synchronization

Delaware MMIS Interfaces

The current Delaware Legacy MMIS interfaces with the following agencies/entities and systems by business area:

Client Interfaces	
1	Delaware Client Information System (DCIS II): includes transactions for passing client demographic data, eligibility segment data, LTC data, and Buy-In data a. Social Security Administration: i. SDX ii. Beneficiary Data Exchange System (BENDEX) b. DPH Bureau of Vital Statistics
2	CMS: a. Buy-In HCFA Part A & B b. MMA dual eligible response file c. Coordination of benefits (COB) eligibility file (crossover claims) d. SPAP response file
3	Department of Education (DOE): information regarding all Medicaid enrolled children in Delaware regardless of MCO enrollment.
4	DHSS (Department of Health and Social Services): worker interface file provides the name and phone number for each worker.
5	DPH (Department of Public Health) – Vaccine for Children (VFC) information system. This information includes immunization data, client demographics, provider demographics, insurance information, vital statistics and historical data.
6	Division of Management Services (DMS) Integrated Services Information System (ISIS): Part C Program.
7	Division of Substance Abuse and Mental Health (DSAMH): contains all clients who are currently being managed by Delaware Physicians Care Inc (Aetna) and United Health Community Plan.
8	DSCYF (Department of Services for Children, Youth, and Families), Family And Child Tracking System (FACTS) provides eligibility and managed care information.
9	Peer/Utilization Review Organization.
10	TPL contractor resource files.
11	Decision Support System/Data Warehouse.*
12	Card production facility to generate plastic ID cards.

*** Interfaces anticipated, but yet to be built in the legacy system**

Provider Interfaces	
1	Clinical Laboratory Improvement Amendment (CLIA) information.
2	DPH will send two files to FA: VFC client information, and claims files The client information will contain data on all clients for which claims are submitted. Claims are sent using the HIPAA 837 transaction format.
3	Division of Professional Regulation Licensing Board, license renewal information.

Reference Data Maintenance Interfaces	
1	From CMS: a. Healthcare Common Procedures Coding System (HCPCS) procedure code data (includes CPT codes) b. HCIA ICD-9 to CPT Cross-Reference file c. Medicare Radiology and Physician Fee schedule

Reference Data Maintenance Interfaces	
	d. Medicare Laboratory Fee schedule e. Medicare Ambulatory Surgical Center Fee Schedule From NDAS: f. NDAS Dental Fee Schedule From Ingenix: g. The ICD-9/ICD-10 procedure codes and diagnosis codes
2	Micromedex/Drug Formulary File: contains NDC-related information, such as therapeutic class, generic formulation code, label name, minimum and maximum dose, and day's supply, as well as pricing and rebate data.

Claims Control/Claims Entry	
1	Electronic Claims Management System: manages electronic claims submission using X12 and NCPDP file formats.

Third Party Liability (TPL)	
1	HMS: Carrier and other Insurance to HMS Interface is part of the Data Match and Billing business function.
2	DCIS II: for the purpose of sharing TPL information. The interface sends a daily file consisting of TPL Medical Coverage information that has changed from the MMIS to DCIS II.
3	Delaware Medicaid Managed Care Organizations (MCOs): For the purpose of sharing TPL information. The interface sends a file consisting of all TPL information from the MMIS for any clients enrolled in their MCO.
4	Child Support Unit and State MCOs (Lead Entities): for the purpose of sharing child support information and the State MCOs input files.
5	Decision Support System/Data Warehouse.*
6	Other governmental agencies through data matching.
7	The TPL vendor private insurers, such as health and automobile, through data matching.
8	Department of Labor, Insurance Commissioner's Office, and employers.

*** Interfaces anticipated, but yet to be built in the legacy system**

Pharmacy: POS, ePrescribing, DUR and Consultative Services	
1	Manufacturer Drug Rebate electronic invoice file: created quarterly from the drug rebate extract files.
2	HCFA: CMS Drug Rebate tape to update the drug rebate rates and manufacturer information tables.
3	Paid claim drug extract record.
4	Web Portal: All of the Drug Rebate data is accessible online, including drug manufacturer information, drug rebate financial transactions, drug rebate invoicing, and rebate information on the drug file.
5	Pro-DUR information (Micromedex): Used to update therapeutic class, disease, diagnosis, age, early/late refill, minimum/maximum dose, drug interactions, drug/disease inferred, duration of therapy, and pregnancy, on individual MMIS drug information tables.
6	Retro-DUR: create an extract file of provider, client, medical claims data and pharmacy claims data of claims that have already been paid to send to DUR contractor (currently Health Information Design).
7	Decision Support System/Data Warehouse.*
8	Electronic Verification Systems (EVS).
9	ePrescribing: The following files are sent to/retrieved from the Surescripts site:

Pharmacy: POS, ePrescribing, DUR and Consultative Services	
	a. Formulary and benefit file b. Formulary and benefit file response file c. Client ID load file d. Client ID load response file

*** Interfaces anticipated, but yet to be built in the legacy system**

Financial	
1	Internal Revenue Service (IRS): Creates a tape file from the MMIS of all providers' 1099 earnings information for the calendar Year to be reconciled to IRS 1099 files.
2	Banking Institution.
2.a	Recon file received from the banking institution contains information including the external check number, the date the check was processed by the bank, the check amount, and the check status.
2.b	Electronic Funds Transfer (EFT) Extract file: transferred to the banking institution from the MMIS to transfer funds to the provider's financial institutions. This file contains the provider paid amount, payment dates, and the provider's bank information.
2.c	Bank Payment Extract: Contains a listing of all external checks that were either issued or voided during the week. The file delivered to the banking institution includes: payment amount, payment date, check status, check name, check number and account number.
3	Electronic Remittance ANSI 277: Pended claims are formatted to a claim status response transaction and sent to the ECMS.
4.	Electronic Remittance ANSI 835: Creates extract records for paid claims, denied claims, adjusted paid claims, adjusted denied claims, system payouts, and recoupments that interface with the financial A/R function.
5	Automated interface between claims processing/claims payment and the First State Financial (FSF) accounting system.
6.	National Level Repository (NLR) a national repository for providers who are requesting EHR incentive payments.

Managed Care	
1	Remittance Processing Center: Two files are received containing payment transactions for managed care premiums one from the remittance processing center the other is a network file from cash payment services.
2	Health Benefits Manager for outgoing call services to clients and response file processing.
3	Managed Care Pharmacy Extract interface transaction extracts pharmacy claims data for those clients enrolled with a MCO.
4	MCO file of their contracted providers.
5	Managed Care Client Primary Care Physician (PCP) Update transaction.
6	Managed Care Actuarial Client Creation interface transaction extracts managed care client data for use by the State's actuarial firm.
7	Managed Care Actuarial Provider Creation interface transaction extracts managed care provider data for use by the State's actuarial firm.
8	Managed Care Actuarial Pharmacy Creation interface transaction extracts pharmacy claim data for use by the State's actuarial firm.
9	Managed Care Actuarial Encounter Creation interface transaction extracts encounter claim data for use by the State's actuarial firm.
10	Decision Support System/Data Warehouse.*
11	Interface with the State's Health Insurance Exchange.*

Managed Care	
12	Interface with the State Eligibility System (currently DCIS II).

*** Interfaces anticipated, but yet to be built in the legacy system**

I ATTACHMENT I: STATE RESPONSIBILITIES AND DMES PROJECT TEAM COMPOSITION

I.1 State Responsibilities

The following are State responsibilities under this RFP. Outlined in the following subsections are areas such as project staffing, project organization, available resources, system testing/implementation, and IV & V responsibilities and scope..

I.1.1 Staffing Roles

IRM will provide a Project Director and Deputy Director to oversee this project. These people will be responsible for full project oversight to ensure that project leadership, technical staff, functional staff, the project management office (PMO), steering committee, and IV&V staff roles are being fulfilled at a level that will lead to a successful project implementation.
IRM will appoint a Project Director. The Project Director will serve to manage project staff including Contractor staff during this project. The Project Director will serve as the overall project lead with input from IRM Technical team staff, the PMO, Functional Manager, and Project Steering Committee. The Director will assure that appropriate staff contribute to the detailed requirements and design of the solution, review project documents and deliverables thoroughly, and test the system adequately. Additionally, the director will assure coordination between each project group, involve the steering committee, and escalate issues to the executive committee.

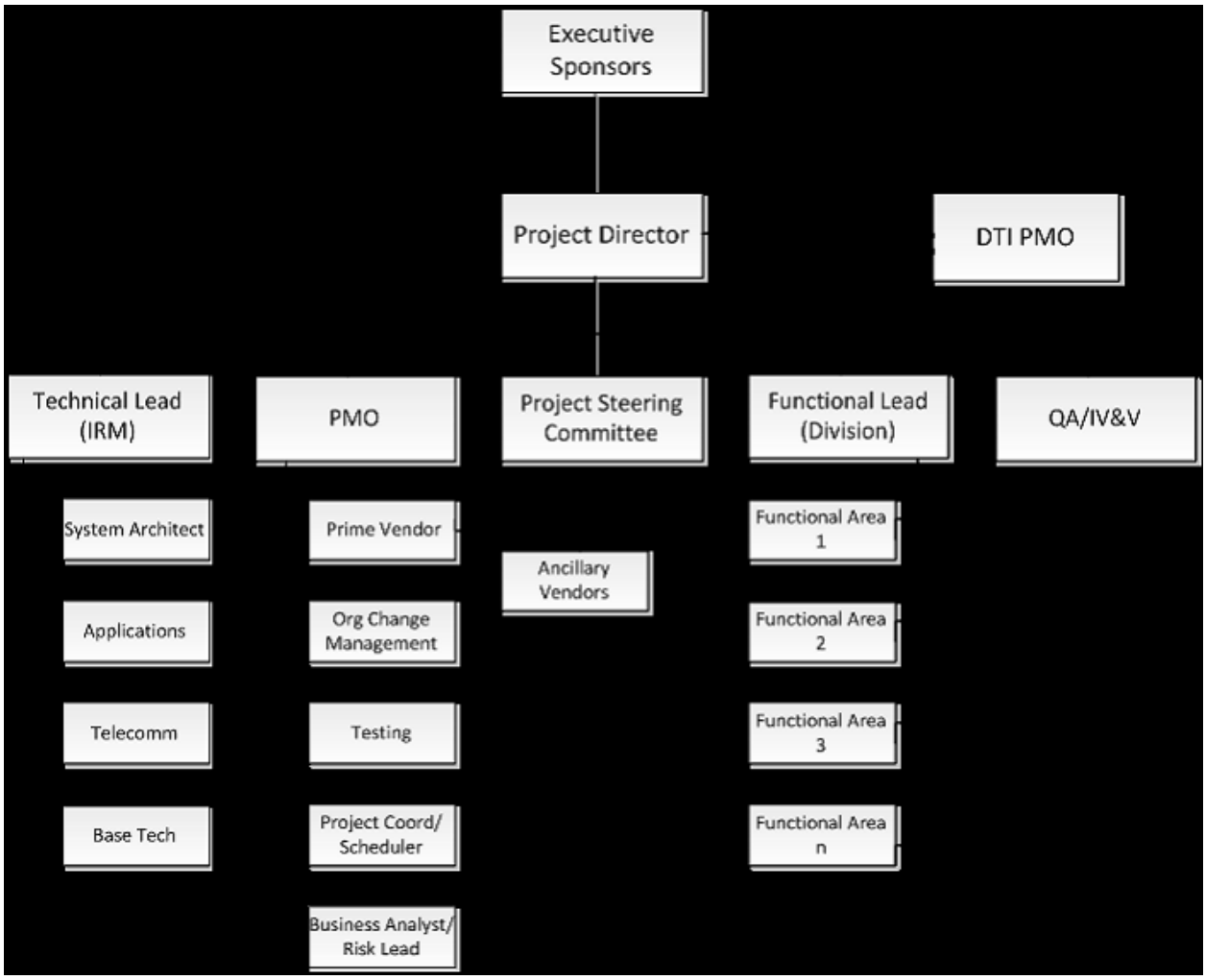
IRM will provide a Technical Project Manager and Technical Project Manager Assistant to serve as the primary technical liaison with the State to ensure that Contractor and State technical staff work together effectively to identify current and future technology considerations and make key technology decisions. .

DMMA will appoint a Functional Lead to coordinate and guide the activities of the subject matter experts to assure that the appropriate and timely Medicaid business decisions are made.

The Project Director will lead, coordinate, and solicit advice from a Project Steering Committee made up of representative managers from the Division, IRM, and other areas of the Department. This Committee will meet frequently, monthly at minimum, to review project status, progress and issues. The Project director will report to the Executive Sponsors. The Executive Sponsors will be made up of State representatives including executive members of DHSS. They will meet at least bi-monthly to discuss overall project status, progress and issues, project management, funding, staffing, sponsor issues, stakeholder participation and tasks planned for the upcoming quarter.

I.1.1.1 Project Organization Chart

The following organization chart outlines the proposed management structure for this project.



I.1.1.2 State Staff Participation

The IRM and DMMA staff listed above will be assigned to work on this project full time. Additional State staff participation is as assigned and is in addition to their primary responsibilities. State staff normally work 7.5 hour days from 8:00 a.m. – 4:30 p.m., although some staff flex their schedules. No State staff will be available for data cleanup or meta-data definition. State staff will be available to consult with the Contractor on the data needing to be cleaned up for conversion. However, divisional SME's can serve to advise contractor on these topics. No State technical staff will be assigned to this project to assist in the coding of the system. State staff will attend JAD sessions as assigned. It is important to note that documentation on the existing systems may be missing, incomplete, out of date or in error. Divisional staff will be responsible for user acceptance testing. The Division will be responsible for assigning a primary and backup division liaison and knowledgeable subject matter experts for the duration of JAD sessions related to their areas of expertise. These assignments will be sent to the Project Director prior to the start of the JAD sessions. Attendance at these sessions

is mandatory for assigned staff. These same subject matter experts along with other staff will be assigned to participate during UAT for their areas of expertise. Adequate divisional staff participation is critical..

I.1.2 Resource Availability

During State business days, the Biggs mainframe production systems are normally available from 7:00 a.m. to 6:00 p.m. On Saturday the hours are 8:00 a.m. to 4:30 p.m. Production systems are taken down earlier on specific monthly dates to accommodate particularly heavy batch schedules. Test systems availability will be scheduled in concert with other development staff. DTI has mainframe systems support staff on site from 7:00 a.m. to 4:30 p.m. DTI Operations staff are on site 24x7. IRM applications, telecommunications and Helpdesk staff are on site from 8:00 a.m. to 4:30 p.m. on State business days. The State network is very stable and unscheduled downtime is minimal. Given that the network is an essential state resource, any reported problems have a very high priority and are dealt with immediately. Biggs Data Center power is conditioned and outside supply fluctuations can trigger a switch to automatic local power generation capability. The State has audio and video-conferencing capabilities as well in specific onsite locations for remote meeting participation. Remote connectivity through Secure Socket Layer, Virtual Private Network (SSL-VPN) is available for offsite work for contracted staff that must access, update or maintain servers and/or applications in the Demilitarized Zone (DMZ). Please refer to Appendix D for more information on the DHSS IT environment.

I.1.3 Deliverable Review

It is the responsibility of the State to perform deliverable review including User Acceptance Testing on all functional aspects of the project. DTI project Director, will participate in the review process for deliverables. It is the responsibility of the State to review all project deliverables in the agreed upon timeframe. Deliverable signoff is required by the Technical Lead, Functional Lead and Project Director. The State will notify the bidder of any changes to the review schedule. Milestone invoicing and payment is contingent upon formal State approval. Likewise, production implementation of each module is contingent upon formal State approval.

I.1.3.1 Implementation

Production implementation is normally an IRM responsibility. Depending on the solution selected, IRM may require participation of contractor staff to oversee implementation if the solution is hosted remotely. The state will be primarily responsible for post implementation administration if the system resides at the Biggs Data Center. If an Application Service Provider (ASP) solution is selected, the Contractor has primary administration responsibilities.

I.2 Independent Verification and Validation (IV&V)

Independent Verification and Validation (IV&V) is a set of activities performed by an entity not under the control of the Contractor. DHSS will select an IV&V Contractor technically, managerially and financially independent of the Contractor that will check that the proposed DMES as provided by the Contractor meets the users' needs (Validation) and is well engineered (Verification). During all phases of the DMES Procurement Contract, the IV&V Contractor will be acting with the full authority of the State in performing evaluation activities.

I.2.1 IV&V Scope

The selected IV&V Contractor will be required to perform the following series of Verification and Validation tasks. The Contractor must provide access to systems, data, personnel, and documentation as appropriate to support these activities.

1. Project Management: The IV&V Contractor will evaluate project progress, resources, budget, schedules, work flow, and reporting. The IV&V Contractor will provide oversight management of the Project Management Plan created by the Contractor to ensure the plan is being followed, evaluate the effectiveness of the plan to keep the project on schedule, and review the Contractor and subcontractors associated reporting.
2. Training: The IV&V Contractor will review and make recommendations on the training provided to the DMES's users. This will include verifying sufficient knowledge transfer for maintenance and operation of the new system.
3. Requirements Management: The IV&V Contractor will evaluate and make recommendations on the project's process and procedures for managing requirements.
4. Operating Environment: The IV&V Contractor will evaluate and make recommendations regarding new system hardware configurations to determine if their performance is adequate to meet current and future system requirements.
5. Development Environment: The IV&V Contractor will evaluate and make recommendations regarding new development hardware configurations to determine if their performance is adequate to meet the needs of system development.
6. Software Development: For any additional software development required, the IV&V Contractor will evaluate and make recommendations on existing high level design products to verify the design is workable, efficient, and satisfies all system and system interface requirements.
7. Testing: The IV&V Contractor will evaluate the plans, requirements, environment, tools, and procedures used to test the DMES and ensure that it works according to specifications, is efficient, and satisfies all system and system interface requirements.
8. Data Management: The IV&V Contractor will evaluate any needed plans, procedures and software for data conversion and evaluate proposed database re-design activity to determine if it meets the proposed system requirements.
9. Operations Oversight: The IV&V Contractor will evaluate change request and defect tracking processes, evaluate user satisfaction with the DMES to determine areas for improvement, evaluate the impact of the DMES on program goals and performance standards, evaluate operational plans and processes, and evaluate implementation of the process activities including backup, disaster recovery and day-to-day operations to verify that processes are being followed.

I.2.2 State Responsibilities for IV&V:

1. Select an IV&V Contractor to evaluate Contractor and DHSS implementation, operations, and other activities
2. Approve IV&V Plan and communicate expectations to Contractor
3. Attend scheduled meetings with the Contractor, subcontractors and IV&V Contractor
4. Serve as the final authority on disputes that may arise between the Contractor and the IV&V Contractor

I.2.3 Prime Responsibilities for IV&V

1. Provide the IV&V Contractor access to the Contractor's project management plan, including recommendations for: adequate staff; staff skills, positions and abilities; equipment resources; training and facilities
2. Provide the IV&V Contractor access to project software development documents
3. Facilitate IV&V Contractor review and monitoring of development processes to ensure they are being documented, carried out, and analyzed for improvement
4. Facilitate IV&V Contractor review of project deliverables for accuracy, completeness, and adherence to contractual and functional requirements
5. Facilitate IV&V Contractor review of the system documentation (Requirements, Training, Test Plans, etc.) for accuracy and completeness
6. Facilitate IV&V Contractor analysis of applications, network, hardware and software operating platform performance characteristics relative to expected, anticipated, and contractually guaranteed results and industry standards/expectations
7. Facilitate IV&V Contractor assessment of software testing
8. Facilitate IV&V Contractor assessment of user and system training
9. Facilitate IV&V Contractor review of system hardware and software configuration.
10. Facilitate IV&V Contractor review and assessment of any other development or operational areas governed by the Contractor's Contract and Proposal and as identified in the IV&V plan approved by the State.

J ATTACHMENT J: DELAWARE MEDICAID BENEFIT PLANS AND WAIVER SERVICES

The Delaware Medical Assistance Program (DMAP) pays claims for services in two ways. The first method is the traditional fee-for-service (FFS) method, in which providers submit claims for individual covered services enumerated in the Delaware Medicaid State Plan provided to eligible Medicaid clients. The second method is a capitated payment arrangement which results in a single payment per member per month. This payment method is currently used for payments for clients who are enrolled in a commercial managed care organization (MCO), a Program of All-Encompassing Care for the Elderly (PACE) or are covered under the Transportation Broker contract for non-emergency transportation (NET). In the case of the MCO and PACE capitation payments, the capitated payment covers multiple services that are in the defined benefit package of each program.

Delaware Medical Assistance Programs

The Division of Medicaid and Medical Assistance (DMMA) manages the following medical assistance programs:

1. Medicaid (including acute care, institutional long-term care and home and community based long-term care, and specialized family planning services).
2. Medicaid “Buy-in” Programs for Medicare.
3. Delaware Healthy Children Program (DHCP).
4. Delaware Prescription Assistance Program (DPAP).
5. Chronic Renal Disease Program (CRDP).
6. Other Medical Assistance Programs.

Medicaid

Medicaid pays for medical care provided to eligible low-income children and families and to eligible aged, blind, and/or disabled people who meet the financial and medical criteria established by DMMA.

Even though the administration of the Delaware Medicaid program is performed by DMMA, the Delaware Department of Health and Social Services (DHSS) has been designated as the “single state agency” to administer the Title XIX State Plan as per 42 CFR 430.10. As of May 2012, there were approximately 210,000 Delawareans eligible for Medicaid.

Since 1996, Delaware has been operating its Medicaid program under a 1115 waiver that allows it to operate a mandatory managed care program for categorical Medicaid eligibles, as well as provide medical coverage to two groups of individuals that would not be eligible under the State Plan: uninsured adults with incomes below 100 percent of the Federal Poverty Level (FPL) and women of child bearing age with incomes below 200 percent FPL (this latter group is only eligible to receive family planning services). Delaware calls its managed care program, the Diamond State Health Plan (DSHP). Effective April 1, 2012, individuals who are dually eligible for Medicare and full Medicaid and individuals receiving long-term care services were added under the DSHP. In addition, long-term care services and supports were added as a benefit under the DSHP for individuals who meet institutional “level of care” requirements. The new

long-term care benefit package and the individuals who are able to receive it are referred to as DSHP “Plus.” As of May 2012, approximately 83 percent of all Delaware Medicaid clients were enrolled in managed care. Clients eligible for Medicaid under the Division of Developmental Disabilities Services Home and Community Based Services (HCBS) waiver program and partial dual-eligibles are still excluded from managed care. Individuals eligible for Medicaid under the Family Planning Expansion Group and the Breast and Cervical Cancer Program are also excluded from managed care.

Most traditional Medicaid benefits are included in the capitated managed care benefit package with some notable exceptions including: pharmacy, dental, non-emergency transportation and extended behavioral health benefits. Most Medicaid clients enrolled in the DSHP are enrolled with one of two commercial managed care plans, 1) Delaware Physicians Care, Inc. (DPCI) operated by Aetna and 2) United Health Care Community Plan operated by United Healthcare. The remaining DSHP clients are enrolled in the State-operated managed care option called Diamond State Partners (DSP), which has less than 4,500 clients and for which enrollment is currently closed. DSP was created in 2004 when only one commercial MCO participated in the DSHP. Delaware established the DSP program in order to provide choice of at least two health plans, as required under 42 CFR 438.52. A contracted enrollment broker assists clients in selecting a health plan.

Medicaid “Buy In” Programs for Medicare Beneficiaries

In addition to the comprehensive medical benefits provided under Delaware’s Medicaid program, DMMA also coordinates with the Social Security Administration (SSA) to assist low-income Delawareans (gross monthly income of less than 100 percent of the FPL) in accessing Medicare benefits. These programs require file exchanges between DMMA and SSA.

Under the Qualified Medicare Beneficiary (QMB) Program, DMMA may pay Medicare Part A and Part B premiums and, in some cases, other "out-of-pocket" expenses such as deductibles and coinsurance. Individuals must be entitled to Medicare Part A to qualify for any of these programs. Clients under these programs do not receive regular Medicaid services. Under the QMB Program, Medicaid pays for the following:

1. The Medicare Part A hospital premium (if needed).
2. The Medicare Part B premium.
3. The Medicare Part A hospital deductible.
4. The annual Medicare Part B deductible.
5. The 20 percent coinsurance (for services such as physician visits and lab work).

Under the Specified Low Income Medicare Beneficiary (SLMB) Program, Medicaid pays the Medicare Part B premium only. Gross monthly income cannot exceed 120 percent of the FPL.

Under the Qualified Individual-1 (QI-1) Program, Medicaid pays the Medicare Part B premium only. Gross monthly income cannot exceed 135 percent of the FPL.

Delaware Healthy Children Program

DHCP is a medical assistance program authorized under Title XXI of the Social Security Act, the Children’s Health Insurance Program. In Delaware, children under age 19 whose families

have incomes below 200 percent of FPL, but who do not qualify for Medicaid and who do not have comprehensive health insurance may qualify for DHCP.

The DHCP covers most of the same services covered under the Medicaid State Plan. Families eligible for DHCP must pay a monthly premium in order to be enrolled. DHCP clients must also enroll in a managed care plan in order to be covered. The fiscal agent collects the monthly premiums.

Delaware Prescription Assistance Program

The Delaware Prescription Assistance Program (DPAP) assists certain low-income elderly and/or disabled individuals in paying for prescription medications and Medicare Part D premiums. The program is designed to aid eligible Delaware residents who:

- Have no prescription insurance other than Medicare Part D
- Have income at or below 200 percent of the FPL
- Are at least 65 years old, or
- Qualify for Social Security Disability benefits and whose prescription costs exceed 40 percent of their income.

The DPAP will pay up to $3,000 per year for each eligible individual toward medically necessary prescription drugs and Part D premiums. The program does not pay for diabetic drugs or supplies for Medicare recipients. Medicare currently provides this coverage for both insulin and non-insulin dependent patients.

Clients must make a co-payment of 25 percent of the cost of the prescription, or a minimum of $5. The co-pay is collected by the dispensing pharmacy, which submits a claim to DPAP and is reimbursed directly.

Chronic Renal Disease Program

The Chronic Renal Disease Program (CRDP) was established to provide a limited medical benefit that includes transportation, prescriptions, and nutritional supplements to Delaware residents diagnosed with End Stage Renal Disease (ESRD). The State of Delaware provides 100 percent of the funding for this program, which is administered by the DMMA. Since State funds are limited, ensuring the widest coverage requires that all third-party resources (Medicare, Medicaid, Veteran Affairs (VA), and private insurance) must be considered before CRDP funds are used.

Other Medical Assistance Programs in the MMIS

In addition to the four medical assistance programs operated by DMMA, claims are also processed in the MMIS for other medical assistance programs including:

- Part C of IDEA (Individuals with Disabilities Education Act) – A state and federal funded program that provides early intervention services to individuals from birth to age 3
- Delaware Cancer Treatment Program (DCTP) – A state funded program that provides targeted medical assistance to individuals who have been diagnosed with cancer and have no other comprehensive insurance coverage

- Vaccines for Children – A state funded program that pays a vaccine administration fee to physicians who participate in the program that utilizes free or low-cost vaccines made available by the Centers for Disease Control and Prevention (CDC). Claims for the vaccine administration fee are processed in the MMIS for non-Medicaid eligible children.

K ATTACHMENT K: COST PROPOSAL

PRICING SCHEDULE A

SUMMARY OF TOTAL PROPOSAL

A	B	C
1	Total Price of Delaware Medicaid Enterprise System (DMES) Planning, Design, Development, Testing, and Implementation (Schedule B-1, Line 10, Column C)	$_____
2	Total Operational Price (Schedule C, Line 1, Column G)	$_____
3	Total Price of POS PBM Planning, Design, Development, Testing, and Implementation (Schedule D-1, Line 10, Column C)	$_____
4	Total POS PBM Operational Price (Schedule E, Line 1, Column G)	$_____
5	Total Contract Price	$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE B

DELAWARE MEDICAID ENTERPRISE SYSTEM PLANNING, DESIGN, DEVELOPMENT, TESTING AND IMPLEMENTATION PRICE COMPONENTS FROM CONTRACT AWARD THROUGH JUNE 30, 2016.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Database and Systems Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainers	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical and Administrative	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

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Signature of Corporate Official Title Date

PRICING SCHEDULE B-1

DELAWARE MEDICAID ENTERPRISE SYSTEM PLANNING, DESIGN, DEVELOPMENT, TESTING AND IMPLEMENTATION MILESTONE PAYMENTS

Tasks are shown as a percentage of the total from Pricing Schedule B. The total of Column C must equal the total of Line 10, Pricing Schedule B.

	A	B	C
#	Month/Year	Milestones	Total Phase Price
Design and Development			
1	February 2014	Task 1 – Project Management Oversight and Planning (4%)	
2	March 2014	Task 2 – Detailed Requirements Analysis (5%)	
3	September 2014	Task 3 –Design (4%)	
4	March 2015	Task 4 – Development (45%)	
Implementation			
5	January 2016	Task 5 – Data Conversion (7%)	
6	March 2016	Task 6 – Acceptance Testing (9%)	
7	May 2016	Task 7 – Training (7%)	
8	July 2016	Task 8 – Implementation (9%)	
Operation			
9	July 2017	Task 10 – Certification (10%)	
10	TOTAL (Must match the sum on Line 10, Schedule B.)		

Post total Line 10 on column C to Schedule A, Line 1.

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE C

OPERATIONAL PRICE SUMMARY

(A) Price Components	(B) Year 1 (2016-2017)	(C) Year 2 (2017-2018)	(D) Year 3 (2018-2019)	(E) Year 4 (2019-2020)	(F) Year 5 (2020-2021)	(G) Total	(H) 5 Year Average
1. Total Price All Components (From C1-C5, Line 10)	$_____	$_____	$_____	$_____	$_____	$_____	
2. Price Per Month (Line 1 / 12 mo.)	$_____	$_____	$_____	$_____	$_____		
3. Five Year Average Price Per Month (Line 1G / 60mo.)							$_____

NOTE: **1b should equal Schedule C-1, Line 10**
1c should equal Schedule C-2, Line 10
1d should equal Schedule C-3, Line 10
1e should equal Schedule C-4, Line 10
1f should equal Schedule C-5, Line 10
1g should be entered on Schedule A, Line 2

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED

Signature of Corporate Official Title Date

PRICING SCHEDULE C-1

OPERATIONAL PRICE COMPONENTS FROM JULY 1, 2016 THROUGH JUNE 30, 2017

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Database and Systems Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainers	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical and Administrative	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

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Signature of Corporate Official Title Date

PRICING SCHEDULE C-2

OPERATIONAL PRICE COMPONENTS FROM JULY 1, 2017 THROUGH JUNE 30, 2018.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Database and Systems Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainers	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical and Administrative	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE C-3

OPERATIONAL PRICE COMPONENTS FROM JULY 1, 2018 THROUGH JUNE 30, 2019.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
1a.	Management	_____	$_____	$_____
1b.	Supervision	_____	$_____	$_____
1c.	Project Management Staff	_____	$_____	$_____
1d.	QA Staff	_____	$_____	$_____
1e.	Database and Systems Administrator	_____	$_____	$_____
1f.	Senior Programmer/Analyst	_____	$_____	$_____
1g.	Programmer/Analyst	_____	$_____	$_____
1h.	Trainers	_____	$_____	$_____
1i.	Field Representative	_____	$_____	$_____
1j.	Service Representative	_____	$_____	$_____
1k.	Clerical and Administrative	_____	$_____	$_____
1l.	Medical Professionals	_____	$_____	$_____
1m.	Other Professionals	_____	$_____	$_____
1n.	Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
9a.	_____	_____	$_____	$_____
9b.	_____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE C-4

OPERATIONAL PRICE COMPONENTS FROM JULY 1, 2019 THROUGH JUNE 30, 2020.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
1a.	Management	_____	$_____	$_____
1b.	Supervision	_____	$_____	$_____
1c.	Project Management Staff	_____	$_____	$_____
1d.	QA Staff	_____	$_____	$_____
1e.	Database and Systems Administrator	_____	$_____	$_____
1f.	Senior Programmer/Analyst	_____	$_____	$_____
1g.	Programmer/Analyst	_____	$_____	$_____
1h.	Trainers	_____	$_____	$_____
1i.	Field Representative	_____	$_____	$_____
1j.	Service Representative	_____	$_____	$_____
1k.	Clerical and Administrative	_____	$_____	$_____
1l.	Medical Professionals	_____	$_____	$_____
1m.	Other Professionals	_____	$_____	$_____
1n.	Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
9a.	_____	_____	$_____	$_____
9b.	_____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE C-5

OPERATIONAL PRICE COMPONENTS FROM JULY 1, 2020 THROUGH JUNE 30, 2021.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
1a.	Management	_____	$_____	$_____
1b.	Supervision	_____	$_____	$_____
1c.	Project Management Staff	_____	$_____	$_____
1d.	QA Staff	_____	$_____	$_____
1e.	Database and Systems Administrator	_____	$_____	$_____
1f.	Senior Programmer/Analyst	_____	$_____	$_____
1g.	Programmer/Analyst	_____	$_____	$_____
1h.	Trainers	_____	$_____	$_____
1i.	Field Representative	_____	$_____	$_____
1j.	Service Representative	_____	$_____	$_____
1k.	Clerical and Administrative	_____	$_____	$_____
1l.	Medical Professionals	_____	$_____	$_____
1m.	Other Professionals	_____	$_____	$_____
1n.	Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
9a.	_____	_____	$_____	$_____
9b.	_____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE D – POS PBM Pricing

DMES POS PBM PLANNING, DESIGN, DEVELOPMENT, TESTING AND IMPLEMENTATION PRICE COMPONENTS FROM CONTRACT AWARD THROUGH JUNE 30, 2016.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Database and Systems Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainers	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical and Administrative	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE D-1 – POS PBM Pricing

DMES POS PBM PLANNING, DESIGN, DEVELOPMENT, TESTING AND IMPLEMENTATION MILESTONE PAYMENTS

Tasks are shown as a percentage of the total from Pricing Schedule D. The total of Column C must equal the total of Line 10, Pricing Schedule D.

	A	B	C
#	Month/Year	Milestones	Total Phase Price
Design and Development			
1	February 2014	Task 1 – Project Management Oversight and Planning (4%)	
2	March 2014	Task 2 – Detailed Requirements Analysis (5%)	
3	September 2014	Task 3 –Design (4%)	
4	March 2015	Task 4 – Development (45%)	
Implementation			
5	January 2016	Task 5 – Data Conversion (7%)	
6	March 2016	Task 6 – Acceptance Testing (9%)	
7	May 2016	Task 7 – Training (7%)	
8	July 2016	Task 8 – Implementation (9%)	
Operation			
9	July 2017	Task 10 – Certification (10%)	
10	TOTAL (Must match the sum on Line 10, Schedule D.)		

Post total Line 10 on column C to Schedule A, Line 3.

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE E – POS PBM Pricing

OPERATIONAL PRICE SUMMARY

(A) Price Components	(B) Year 1 (2016-2017)	(C) Year 2 (2017-2018)	(D) Year 3 (2018-2019)	(E) Year 4 (2019-2020)	(F) Year 5 (2020-2021)	(G) Total	(H) 5 Year Average
4. Total Price All Components (From C1-C5, Line 10)	$_____	$_____	$_____	$_____	$_____	$_____	
5. Price Per Month (Line 1 / 12 mo.)	$_____	$_____	$_____	$_____	$_____		
6. Five Year Average Price Per Month (Line 1G / 60mo.)							$_____

NOTE: **1b should equal Schedule E-1, Line 10**
1c should equal Schedule E-2, Line 10
1d should equal Schedule E-3, Line 10
1e should equal Schedule E-4, Line 10
1f should equal Schedule E-5, Line 10
1g should be entered on Schedule A, Line 4

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED

Signature of Corporate Official Title Date

PRICING SCHEDULE E-1 – POS PBM Pricing

OPERATIONAL PRICE COMPONENTS FROM JULY 1, 2016 THROUGH JUNE 30, 2017

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Database and Systems Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainers	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical and Administrative	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE E-2 – POS PBM Pricing

OPERATIONAL PRICE COMPONENTS FROM JULY 1, 2017 THROUGH JUNE 30, 2018.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
1a.	Management	_____	$_____	$_____
1b.	Supervision	_____	$_____	$_____
1c.	Project Management Staff	_____	$_____	$_____
1d.	QA Staff	_____	$_____	$_____
1e.	Database and Systems Administrator	_____	$_____	$_____
1f.	Senior Programmer/Analyst	_____	$_____	$_____
1g.	Programmer/Analyst	_____	$_____	$_____
1h.	Trainers	_____	$_____	$_____
1i.	Field Representative	_____	$_____	$_____
1j.	Service Representative	_____	$_____	$_____
1k.	Clerical and Administrative	_____	$_____	$_____
1l.	Medical Professionals	_____	$_____	$_____
1m.	Other Professionals	_____	$_____	$_____
1n.	Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
9a.	_____	_____	$_____	$_____
9b.	_____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE E-3 – POS PBM Pricing

OPERATIONAL PRICE COMPONENTS FROM JULY 1, 2018 THROUGH JUNE 30, 2019.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
1a.	Management	_____	$_____	$_____
1b.	Supervision	_____	$_____	$_____
1c.	Project Management Staff	_____	$_____	$_____
1d.	QA Staff	_____	$_____	$_____
1e.	Database and Systems Administrator	_____	$_____	$_____
1f.	Senior Programmer/Analyst	_____	$_____	$_____
1g.	Programmer/Analyst	_____	$_____	$_____
1h.	Trainers	_____	$_____	$_____
1i.	Field Representative	_____	$_____	$_____
1j.	Service Representative	_____	$_____	$_____
1k.	Clerical and Administrative	_____	$_____	$_____
1l.	Medical Professionals	_____	$_____	$_____
1m.	Other Professionals	_____	$_____	$_____
1n.	Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
9a.	_____	_____	$_____	$_____
9b.	_____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE E-4 – POS PBM Pricing

OPERATIONAL PRICE COMPONENTS FROM JULY 1, 2019 THROUGH JUNE 30, 2020.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
1a.	Management	_____	$_____	$_____
1b.	Supervision	_____	$_____	$_____
1c.	Project Management Staff	_____	$_____	$_____
1d.	QA Staff	_____	$_____	$_____
1e.	Database and Systems Administrator	_____	$_____	$_____
1f.	Senior Programmer/Analyst	_____	$_____	$_____
1g.	Programmer/Analyst	_____	$_____	$_____
1h.	Trainers	_____	$_____	$_____
1i.	Field Representative	_____	$_____	$_____
1j.	Service Representative	_____	$_____	$_____
1k.	Clerical and Administrative	_____	$_____	$_____
1l.	Medical Professionals	_____	$_____	$_____
1m.	Other Professionals	_____	$_____	$_____
1n.	Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
9a.	_____	_____	$_____	$_____
9b.	_____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE E-5 – POS PBM Pricing

OPERATIONAL PRICE COMPONENTS FROM JULY 1, 2020 THROUGH JUNE 30, 2021.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
1a.	Management	_____	$_____	$_____
1b.	Supervision	_____	$_____	$_____
1c.	Project Management Staff	_____	$_____	$_____
1d.	QA Staff	_____	$_____	$_____
1e.	Database and Systems Administrator	_____	$_____	$_____
1f.	Senior Programmer/Analyst	_____	$_____	$_____
1g.	Programmer/Analyst	_____	$_____	$_____
1h.	Trainers	_____	$_____	$_____
1i.	Field Representative	_____	$_____	$_____
1j.	Service Representative	_____	$_____	$_____
1k.	Clerical and Administrative	_____	$_____	$_____
1l.	Medical Professionals	_____	$_____	$_____
1m.	Other Professionals	_____	$_____	$_____
1n.	Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
9a.	_____	_____	$_____	$_____
9b.	_____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

Pricing Schedule F – Staffing Rate Card

Schedule F contains single fully loaded hourly rates that shall be used for prioritized system enhancement change control work. These rates will be used for contractor enhancement work that exceeds the base contract allowance (25,000 hours annually) and for other major enhancements under contract amendments as described in Attachment D.

Staffing Rate Card

A	B	C	D	E	F	G
	Staff Category	**Rate per Hour**				
		Year 1 (2016-2017)	Year 2 (2017-2018)	Year 3 (2018-2019)	Year 4 (2019-2020)	Year 5 (2020-2021)
1	Flat hourly rate for all staff					

* For the exercising of the optional extension years, the Staffing Rate Card (Pricing Schedule F) shall not be more than the Bureau of Labor Statistics' Consumer Price Index for all urban consumers for the Philadelphia-Wilmington-Atlantic City metropolitan area, or any successor index, for the previous calendar year.

AN AUTHORIZED CORPORATE OFFICIAL OF THE CONTRACTOR SHALL SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED SHALL BE ENTERED.

Signature of Corporate Official Title Date

L ATTACHMENT L: CONTRACT TERMS AND CONDITIONS

L.1 Terms and Conditions

The following provisions constitute the terms and conditions of the contractual agreement between the State of Delaware, Department of Health and Social Services (DHSS) and its contractor. This section contains terms and conditions specific to this Request for Proposal (RFP). The general terms and conditions are contained in Attachment L – Contract Terms and Conditions, Section L.2. The standard DHSS contract is contained in Attachment L – Contract Terms and Conditions, Section L.5.

L.1.1 Contract Composition

The terms and conditions contained in this section constitute the basis for any contract resulting from this RFP. The State will be solely responsible for rendering all decisions on matters involving interpretation of terms and conditions. All contracts shall be in conformity with, and shall be governed by, the applicable laws of the federal government and the State of Delaware. The following verbiage will replace in its entirety Section B. 16 of the Standard Department Contract.

The term "Contract Documents" shall mean the documents listed below. Each of the Contract Documents is an essential part of the agreement between the Parties, and a requirement occurring in one is as binding as though occurring in all. The Contract Documents are intended to be complementary and to describe and provide for a complete agreement. In the event of any conflict among the Contract Documents, the order of precedence shall be as set forth below:

1. Standard DHSS Department Contract (pages L-12 through L-21 of Attachment L – Contract Terms and Conditions)
2. Division Requirements
3. Contract Amendment(s)
4. RFP Amendment(s) [State responses to Contractor questions and RFP updates if needed are published as RFP Amendment(s)]
5. Published RFP
6. Amendment(s) to Contractor Proposal
7. Contractor Proposal
8. Other Informational Documents

L.1.2 Payment for Services Rendered

Services will be bound by a firm fixed price contract. The firm fixed price will be the Total Cost shown in the pricing schedules in Attachment K - Cost Proposal. Payments will be made based upon the contractor's satisfactory completion and State approval of the identified scheduled milestones.

L.1.3 Contract Term

The maximum term of the project is Contract Length from contract signature. At the State’s sole discretion the contract end date may be extended for up to 6 years in 1-year increments.

The term of this contract is for twenty-nine (29) months of DDI and 5 years of Fiscal Agent (FA) operations with 6 extensions. Any contract awarded hereunder shall commence on or about January 2, 2014, or date of award if later, and shall remain in effect through June 30, 2024 unless sooner terminated under the provisions of this contract. Each term of the contract shall not exceed twelve (12) months, and shall run from July 1 through June 30 each year. One-year renewals are then permitted to allow a longer contract period. Assuming this contract runs the eight full years and all annual extensions are used, the contract end date would be June 30, 2024.

L.1.4 Contractor Personnel

At any time and at its sole discretion, DHSS shall have the right to require the Contractor to remove any individual (either Contractor or subcontractor) from his/her assignment to this contract if, in the opinion of DHSS, such employee is uncooperative, inept, incompetent, or otherwise unacceptable. DHSS will notify the Contractor of this issue in writing and Contractor will immediately comply. The State shall not be invoiced for any further work by this individual after this notification. If the Contractor must make a staff substitution for whatever reason, a staff person with equivalent or better qualifications and experience will be proposed to the State as soon as possible. This proposed candidate will be subject to the same qualifying procedures as the original candidate. The State Project Director and Project Information Resource Management (IRM) Manager must approve this substitution before his/her term on the project begins. In the event that a staff position becomes temporarily or permanently vacant for any reason, including the Contractor's choice to reassign a staff member, DHSS may reduce payments to the Contractor in the amount equal to the vacated position's pay rate for the time period the position is vacant. DHSS may choose to waive its right to reduce payments if the proposed replacement staff member can be approved and can assume the vacated position immediately upon its vacancy.

L.1.5 Funding

This contract is dependent upon the appropriation of the necessary funding.

DHSS reserves the right to reject or accept any bid or portion thereof, as may be necessary to meet its funding limitations and processing constraints.

L.1.6 Confidentiality

The Contractor shall safeguard any client information and other confidential information that may be obtained during the course of the project and will not use the information for any purpose other than the Contract may require.

L.1.7 Method of Payment

The agencies or school districts involved will authorize and process for payment each invoice within 30 days after the date of receipt. The Contractor must accept full payment by procurement (credit) card and or conventional check and/or other electronic means at the State's option, without imposing any additional fees, costs or conditions.

L.1.8 Contract Transition

In the event the Department awards the contract to another Contractor, through contract expiration or termination of this contract, the Contractor will develop a plan to facilitate a smooth transition of contracted functions either back to the Department or to another Contractor designated by the State. This close out plan must be approved by the Department.

L.1.9 Tardiness Sanction

Include this section only if holding a pre bid meeting.

All Bidders who wish to bid on this proposal must be present on time at the mandatory pre-bid meeting. No proposals will be accepted from Bidders who either did not attend the Mandatory Pre-Bid Meeting or who are MORE than 15 minutes late.

L.2 General Terms and Conditions

1. **Proposal Becomes State Property**

   All proposals become the property of the State of Delaware and will not be returned to Bidders.

2. **RFP and Final Contract**

   The contents of this RFP will be incorporated into the final contract and will become binding upon the successful Bidder. If Bidders are unwilling to comply with certain RFP requirements, terms and conditions, objections must be clearly stated in the proposal and will be subject to negotiation at the discretion of the Department.

3. **Proposal and Final Contract**

   The Bidder's proposal will be incorporated into the final contract and be considered binding upon the successful Bidder.

4. **Amendments to Proposals**

   Amendments to proposals will not be accepted after the submission deadline. DHSS reserves the right to request clarification and/or further technical information from any Bidder submitting a proposal at any time.

5. **Cost of Proposal Preparation**

   All costs of proposal preparation will be borne by the Bidder.

6. **Investigation of Contractor's Qualifications**

   The State of Delaware may make such investigation as it deems necessary to determine ability of potential contractors to furnish required services, and Bidders shall furnish the State with data requested for this purpose. The State reserves the right to reject any offer if evidence submitted or investigation of such Bidder fails to satisfy the State that the Bidder is properly qualified to deliver services.

   Bidder shall list all contracts awarded to it or its predecessor firm(s) by the State of Delaware during the last 3 years, by State Department, Division, Contact Person (with address/phone number), period of performance and amount. The Evaluation/Selection Review Committee will consider these as additional references and may contact these sources. Information regarding Bidder performance gathered from these sources may be included in the Committee's deliberations and may be factored into the final scoring of

the bid. Failure to list any contract as required by this paragraph may be grounds for immediate rejection of the bid.

7. **Certifications, Representations, Acknowledgments**

   Using Appendix B, bidding contractors must certify that:

   - They are a regular dealer in the services being procured.
   - They have the ability to fulfill all requirements specified for development with this RFP.
   - They have independently determined their prices.
   - They are accurately representing their type of business and affiliations.
   - They have acknowledged any contingency fees paid to obtain award of this contract.
   - They have included in their quotation all costs necessary for or incidental to their total performance under the contract.
   - They will secure a Delaware Business License.
   - They will secure the appropriate type and amounts of insurance coverage required by the State. Proof of such coverage will be a requirement of the contract.

8. **Ownership Rights**

   The State will retain ownership rights to all materials including software, designs, drawings, specifications, notes, electronically or magnetically recorded material, and other work in whatever form, developed during the performance of this contract. A fundamental obligation herein imposed on the Contractor is the assignment by the Contractor to DHSS of all ownership rights in the completed project. This obligation on the part of the Contractor to assign all ownership rights is not subject to limitation in any respect, whether by characterization of any part of the deliverables as proprietary or by failure to claim for the cost thereof. The provisions of this article shall be incorporated into any subcontract.

9. **Federal/State Access Rights**

   Appropriate federal and/or State representatives will have access to work in progress and to pertinent cost records of the contractor and its subcontractors at such intervals as any representative shall deem necessary.

10. **Reserved Rights of the Department of Health & Social Services**

    The Department reserves the right to:

    - Reject any and all proposals received in response to this RFP.
    - Select for contract or for negotiations a proposal other than that with the lowest cost.
    - Waive any irregularities or inconsistencies in proposals received.
    - Negotiate as to any aspect of the proposal with any proposer and negotiate with more than one proposer at the same time.

- If negotiations fail to result in an agreement within two weeks, terminate negotiations and select the next most responsive proposer, prepare and release a new RFP, or take such other action as the Department may deem appropriate.

11. **Standard for Subcontractors**

    The contract with the prime contractor will bind subcontractors to the prime contractor by the terms, specifications and standards of this statement of work and any subsequent proposals and contracts. All such terms, specifications, and standards shall preserve and protect the rights of the State with respect to the services to be performed by the subcontractor, so that the subcontractor will not prejudice such rights. The use of subcontractors on this project must have the prior approval of the State. Nothing in the RFP shall create any contractual relation between any sub or co-contractor and the State.

12. **Irrevocable License**

    The State of Delaware reserves a royalty-free, exclusive, and irrevocable license to reproduce, publish, or otherwise use the copyright of any deliverables developed under the resulting contract.

13. **Non-Discrimination**

    The selected provider will be required to sign a contract containing a clause that prohibits the provider from discriminating against employees on the basis of their race, color, sex, religion, age, and national origin.

14. **Right to a Debriefing**

    To request a debriefing on a Bidder selection, the Bidder must submit a letter requesting a debriefing to the Procurement Administrator, DHSS, within 10 days of the announced selection. In the letter, the Bidder must specifically state the reason(s) for the debriefing. Debriefing requests must be based on pertinent issues relating to the selection process. Debriefing requests based on specifications in the RFP will not be accepted. All debriefing requests will be evaluated in accordance with these conditions. Debriefing requests that meet these conditions will be reviewed and respectively answered by the Procurement Administrator and/or Debriefing Committee.

15. **Hiring Provision**

    Staff contracted to provide the services requested in this RFP are not precluded from seeking employment with the State of Delaware. The contractor firm selected as a result of this RFP shall not prohibit their employees or subcontractor staff from seeking employment with the State of Delaware.

16. **Anti Lobbying**

    The selected contractor must certify that no federal funds will be used to lobby or influence a Federal officer or a Member of Congress and that the contractor will file required federal lobbying reports.

17. **Anti Kick-back**

    The selected contractor will be expected to comply with other federal statutes including the Copeland "Anti-Kickback Act" (18 U.S.C.874), Section 306 of the Clean Air Act, Section 508 of the Clean Water Act , and the Debarment Act.

18. **Delaware Contract Language**

    Attachment L – Contract Terms and Conditions, Section L.5 contains the DHSS standard contract, which will be used for the agreement between the State and the winning Bidder. The State will not entertain any modifications to the language of this document. By submitting a proposal to this RFP, the Bidder agrees to be bound by the terms and conditions in that contract document.

19. **Project Cost**

    The Department reserves the right to award this project to a Bidder other than the one with the lowest cost or to decide not to fund this project at all. Cost will be balanced against the score received by each Bidder in the rating process. The State of Delaware reserves the right to reject, as technically unqualified, proposals that are unrealistically low if, in judgment of the Selection Committee, a lack of sufficient budgeted resources would jeopardize the successful completion of the project.

20. **Public Record**

    The Department will not divulge specific content of proposals to the extent that the contractor identifies contents as privileged or confidential providing such information resides solely on the one set of CDs labeled as Confidential. Any information not so designated will be considered public information.

21. **Minority/Women/Disadvantaged Business Certification**

    Attachment S – Office of Minority and Women Business Enterprise Certification Tracking Form allows proposers who are certified M/W/D business enterprises to communicate such certification as part of their proposal. Further information, guidelines and forms for such certifications can be found at: http://gss.omb.delaware.gov/omwbe/index.shtml

22. **Consultants and Legal Counsel**

    The State of Delaware may retain consultants or legal counsel to assist in the review and evaluation of this RFP and the Bidders' responses. Bidders shall not contact consultant or legal counsel on any matter related to the RFP.

23. **Contact with State Employees**

    Direct contact with State of Delaware employees other than the State of Delaware Designated Contact regarding this RFP is expressly prohibited without prior consent. Bidders directly contacting State of Delaware employees risk elimination of their proposal from further consideration. Exceptions exist only for organizations currently doing business in the State who require contact in the normal course of doing that business.

24. **Organizations Ineligible to Bid**

    Any individual, business, organization, corporation, consortium, partnership, joint venture, or any other entity including subcontractors currently debarred or suspended is ineligible to bid. Any entity ineligible to conduct business in the State of Delaware for any reason is ineligible to respond to the RFP.

25. **Acknowledgement of Understanding of Terms**

By submitting a bid, each Bidder shall be deemed to acknowledge that it has carefully read all sections of this RFP, including all forms, schedules and exhibits hereto, and has fully informed itself as to all existing conditions and limitations.

26. **Proposal Opening**

The State of Delaware will receive proposals until the date and time shown in this RFP. Proposals will be opened only in the presence of the State of Delaware personnel. Any unopened proposals will be returned to Bidder.

There will be no public opening of proposals but a public log will be kept of the names of all Bidder organizations that submitted proposals. The contents of any proposal shall not be disclosed to competing Bidders prior to contract award.

27. **Non-Conforming Proposals**

Non-conforming proposals will not be considered. Non-conforming proposals are defined as those that do not meet the requirements of this RFP. The determination of whether an RFP requirement is substantive or a mere formality shall reside solely within the State of Delaware.

28. **Realistic Proposals**

It is the expectation of the State of Delaware that Bidders can fully satisfy the obligations of the proposal in the manner and timeframe defined within the proposal. Proposals must be realistic and must represent the best estimate of time, materials and other costs including the impact of inflation and any economic or other factors that are reasonably predictable.

The State of Delaware shall bear no responsibility or increase obligation for a Bidder's failure to accurately estimate the costs or resources required to meet the obligations defined in the proposal.

29. **Proposal Expiration Date**

Prices quoted in the proposal shall remain fixed and binding on the Bidder at least through the first 180 days following receipt of the proposal. The State of Delaware reserves the right to ask for an extension of time if needed.

30. **Exclusions**

The Proposal Evaluation Team reserves the right to refuse to consider any proposal from a Bidder who:

- Has been convicted for commission of a criminal offense as an incident to obtaining or attempting to obtain a public or private contractor subcontract, or in the performance of the contract or subcontract;
- Has been convicted under State or federal statutes of embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, or other offense indicating a lack of business integrity or business honesty that currently and seriously affects responsibility as a State contractor;

- Has been convicted or has had a civil judgment entered for a violation under State or federal antitrust statutes;
- Has violated contract provisions such as:
    - Knowing failure without good cause to perform in accordance with the specifications or within the time limit provided in the contract; or
    - Failure to perform or unsatisfactory performance in accordance with terms of one or more contracts;
    - Has violated ethical standards set out in law or regulation; and
    - Any other cause listed in regulations of the State of Delaware determined to be serious and compelling as to affect responsibility as a State contractor, including suspension or debarment by another governmental entity for a cause listed in the regulations.

L.3 State of Delaware Cloud and Offsite Hosting Specific Terms and Conditions

	Terms and Conditions Clauses 1-9 are mandatory for every engagement. **Exceptions will be considered non-compliant and non-responsive.**	**Vendor's Acknowledgement**
1	The State of Delaware shall own all right, title and interest in its data that is related to the services provided by this contract. The Service Provider shall not access State of Delaware User accounts, or State of Delaware Data, except (i) in the course of data center operations, (ii) response to service or technical issues, (iii) as required by the express terms of this contract, or (iv) at State of Delaware's written request.	
2	Protection of personal privacy and sensitive data shall be an integral part of the business activities of the Service Provider to ensure that there is no inappropriate or unauthorized use of State of Delaware information at any time. To this end, the Service Provider shall safeguard the confidentiality, integrity, and availability of State information and comply with the following conditions: a) Personal information obtained by the Service Provider shall become and remain property of the State of Delaware. b) At no time shall any data or processes which either belongs to or are intended for the use of State of Delaware or its officers, agents, or employees, be copied, disclosed, or retained by the Service Provider or any party related to the Service Provider for subsequent use in any transaction that does not include the State of Delaware.	

	c) The Service Provider shall not use any information collected in connection with the service issued from this proposal for any purpose other than fulfilling the service. d) The Service Provider shall encrypt all non-public data in transit to the cloud during the life of the contract. e) For engagements where the Service Provider stores sensitive personally identifiable information as defined by 6 *Del. C.* § 12B-101(4), such as Social Security Number, Date of Birth, Driver's License number; login credentials, financial data, or federal/state tax information, this data shall be encrypted at rest.	
3	The Service Provider shall not store or transfer State of Delaware data outside of the United States. This includes backup data and Disaster Recovery locations.	
4	The Service Provider shall inform the State of Delaware of any actual security breach that jeopardizes the State of Delaware data or processes. This notice shall be given to the State of Delaware within 24 hours of its discovery. Full disclosure of the jeopardized data shall be made. In addition, the Service Provider shall inform the State of Delaware of the actions it is taking or will take to reduce the risk of further loss to the State.	
5	Delaware Code requires public breach notification when citizen's personally identifiable information is lost or stolen. Reference: 6 *Del. C.* § 12B-101(4). All communication shall be coordinated with the State of Delaware. When the Service Provider is liable for the loss, the State of Delaware shall recover all costs of response and recovery from the breach, for example: 3-year credit monitoring services, mailing costs, website, and telephone call center services. Without limitation of additional legal bases, pursuant to the State of Delaware Constitution of 1897 at Article VIII, §§ 3 and 4 and 29 *Del. C.* § 6519(a) the State of Delaware is not legally permitted to agree to any limitations on liability.	
6	The Service Provider shall contact the State of Delaware upon receipt of any electronic discovery, litigation holds, discovery searches, and expert testimonies related to, or which in any way might reasonably require access to the data of the State. The Service Provider shall not respond to subpoenas, service of process, and other legal requests related to the State of Delaware without first notifying the State unless prohibited by law from	

	providing such notice.	
7	In the event of termination of the contract, the Service Provider shall implement an orderly return of State of Delaware data in a State-defined format and the subsequent secure disposal of State of Delaware data. **Suspension of services:** During any period of suspension, the Service Provider shall not take any action to intentionally erase any State of Delaware data. **Termination of any services or agreement in entirety:** In the event of termination of any services or agreement in entirety, the Service Provider shall not take any action to intentionally erase any State of Delaware data for a period of 90 days after the effective date of the termination. After such 90 day period, the Service Provider shall have no obligation to maintain or provide any State of Delaware data and shall thereafter, unless legally prohibited, delete all State of Delaware data in its systems or otherwise in its possession or under its control. **Post-Termination Assistance:** The State of Delaware shall be entitled to any post-termination assistance generally made available with respect to the Services unless a unique data retrieval arrangement has been established as part of the Service Level Agreement. **Secure Data Disposal** When requested by the State of Delaware, the provider shall destroy all requested data in all of its forms, for example: disk, CD/DVD, backup tape, and paper. Data shall be permanently deleted and shall not be recoverable, according to National Institute of Standards and Technology (NIST) approved methods and certificates of destruction shall be provided to the State of Delaware.	
8	The Service Provider shall conduct criminal background checks and not utilize any staff, including sub-contractors, to fulfill the obligations of the contract who has been convicted of any crime of dishonesty, including but not limited to criminal fraud, or otherwise convicted of any felony or any misdemeanor offense for which incarceration for up to 1 year is an authorized penalty. The Service Provider shall promote and maintain an awareness of the	

	importance of securing the State's information among the Service Provider's employees and agents.	
9	The Service Provider shall comply with and adhere to the following State Policies and Standards available at http://dti.delaware.gov/information/standards-policies.shtml. Data Modeling Standard Strong Password Standard Any future updates to the above State standards and policies that apply to this contract shall be mutually agreed on between both parties and documented via a contract addendum as needed.	
	The applicability of Terms and Conditions Clauses 10-23 depends on the nature of engagement	**Vendor's Acknowledgement**
10	The Service Provider shall allow the State of Delaware access to system security logs, latency statistics, etc. that affect this engagement, its data and or processes. This includes the ability for the State of Delaware to request a report of the records that a specific user accessed over a specified period of time.	
11	The Service Provider shall allow the State of Delaware to audit conformance to the contract terms. The State of Delaware may perform this audit or contract with a third party at its discretion at the State's expense.	
12	The Service Provider shall perform an independent audit of their data centers at least annually at their expense, and provide a redacted version of the audit report upon request. The Service Provider may remove their proprietary information from the redacted version. For example, a Service Organization Control (SOC) 2 audit report would be sufficient.	
13	Advance notice (to be determined at contract time) shall be given to the State of Delaware of any major upgrades or system changes that the Service Provider will be performing. A major upgrade is a replacement of hardware, software or firmware with a newer or better version, in order to bring the system up to date or to improve its characteristics and usually includes a new version number. The State of Delaware reserves the right to defer these changes if desired.	

14	The Service Provider shall disclose its non-proprietary security processes and technical limitations to the State of Delaware such that adequate protection and flexibility can be attained between the State of Delaware and the Service Provider. For example: virus checking and port sniffing – the State of Delaware and the Service Provider shall understand each other's roles and responsibilities.	
15	The Service Provider shall enforce separation of job duties, require commercially reasonable non-disclosure agreements, and limit staff knowledge of customer data to that which is absolutely needed to perform job duties.	
16	The State of Delaware shall have the ability to import or export data in piecemeal or in entirety at its discretion without interference from the Service Provider. This includes the ability for the State of Delaware to import or export data to/from other Service Providers.	
17	The Service Provider shall be responsible for the acquisition and operation of all hardware, software and network support related to the services being provided. The technical and professional activities required for establishing, managing, and maintaining the environment are the responsibilities of the Service Provider. The system shall be available 24 hours per day, 365 days per year basis (with agreed-upon maintenance downtime), providing service to customers as defined in the Service Level Agreement.	
18	The Service Provider shall identify all of its strategic business partners related to services provided under this contract, including but not limited to, all subcontractors or other entities or individuals who may be a party to a joint venture or similar agreement with the Service Provider, who will be involved in any application development and/or operations.	
19	The State shall have the right at any time to require that the Service Provider remove from interaction with State any Service Provider representative who the State believes is detrimental to its working relationship with the Service Provider. The State will provide the Service Provider with notice of its determination, and the reasons it requests the removal. If the State signifies that a potential security violation exists with respect to the request, the Service Provider shall immediately remove such individual. The Service Provider shall not assign the person to any aspect of the contract or future work orders without the State's consent.	
20	The Service Provider shall provide a business continuity and disaster recovery plan upon request and ensure that the State's	

	Recovery Time Objective (RTO) of 24 hours is met.	
21	The Service Provider shall comply with and adhere to the following State Policies and Standards available at http://dti.delaware.gov/information/standards-policies.shtml. Website Common Look and Feel Standard Data Center Policy (meet or exceed level 7) Any future updates to the above State standards and policies that apply to this contract shall be mutually agreed on between both parties and documented via a contract addendum as needed.	
22	The Service Provider shall use web services exclusively to interface with the State's data in near real-time when possible.	
23	The Service provider shall encrypt all State of Delaware non-public data that resides on any Service Provider's mobile devices during the life of the contract.	

MAKE A COPY OF THIS SERVICE PROVIDER AUTORIZATON AND TABLE, SUBMIT AS A MANDATORY REQUIRMENT.

Service Provider Authorizing Official Name:_____

Service Provider Authorizing Official Signature:_____

	Technical Requirements for Cloud and Offsite Hosting	**Response**
1	The Service Provider must include a network diagram of the user's interaction with the solution and any interfaces between the solution and the State needs to be clearly documented (ports, protocols, direction of communication). The network diagram does not need to contain the inner workings of the solution or proprietary information.	
2	The Service Provider must include a list of software that the State needs to utilize the solution. For example, a certain web browser (IE) or web service technology for an interface. The Service Provider will include a list of browsers and versions that are officially supported.	
3	The Service Provider must include a list of any 3rd party authentication solutions or protocols that they support.	
4	The Service Provider must describe any shared infrastructure that is a part of	

	the solution. For example, will the State's data reside in the same database as another customer?	
5	The Service Provider must describe their approach to conveying the 'operational health' of the solution to the State of Delaware. Also, the Service Provider must list any 3rd party cloud management providers that they integrate with.	
6	The Service Provider must describe the method used by the solution for hashing user passwords. Include items like hash algorithm, salt generation and storage and number of iterations.	
7	The Service Provider must describe the solution's ability to encrypt non-public State data at rest. Include encryption algorithm(s) and the approach to key management	
8	The Service Provider must meet or exceed a Tier 4 rating (as defined in the Uptime Institute Guidelines for 2012 or the latest version – Data Center Site Infrastructure Tier Standard – Topology and Data Center Site Infrastructure Tier Standard – Operational Sustainability) for the data center hosting the proposed solution.	

L.4 Acknowledgement of Terms and Conditions

The Bidder must acknowledge receipt, understanding, and compliance with section L.3 titled - Terms and Conditions for Cloud Contracting and External Hosting which includes terms and conditions and requirements.

MAKE A COPY OF THIS ACKNOWLEDGMENT AND SUBMIT AS A MANDATORY REQUIRMENT

Authorized Signatures:
For the Contractor:

_____

Name

_____

Title

_____

Date

L.5 DHSS Standard Contract

(DHSS Standard Contract Boilerplate Approved: 10/06/2008)

CONTRACT

A. Introduction

1. This contract is entered into between the Delaware Department of Health and Social Services (the Department), Division of Medicaid and Medical Assistance (Division) and _____ (the Contractor).
2. The Contract shall commence on _____ and terminate on _____ unless specifically extended by an amendment, signed by all parties to the Contract. Time is of the essence. (Effective contract start date is subject to the provisions of Paragraph C 1 of this Contract.)

B. Administrative Requirements

1. Contractor recognizes that it is operating as an independent Contractor and that it is liable for any and all losses, penalties, damages, expenses, attorney's fees, judgments, and/or settlements incurred by reason of injury to or death of any and all persons, or injury to any and all property, of any nature, arising out of the Contractor's negligent performance under this Contract, and particularly without limiting the foregoing, caused by, resulting from, or arising out of any act of omission on the part of the Contractor in their negligent performance under this Contract.
2. The Contractor shall maintain such insurance as will protect against claims under Worker's Compensation Act and from any other claims for damages for personal injury, including death, which may arise from operations under this Contract. The Contractor is an independent contractor and is not an employee of the State.
3. During the term of this Contract, the Contractor shall, at its own expense, carry insurance with minimum coverage limits as follows:

a.	Comprehensive General Liability	$1,000,000,
	and	
b.	Medical/Professional Liability	$1,000,000/ $3,000,000,
	or	
c.	Misc. Errors and Omissions	$1,000,000/$3,000,000,
	or	
d.	Product Liability	$1,000,000/$3,000,000

All contractors must carry (a) and at least one of (b), (c), or (d), depending on the type of service or product being delivered.

If the contractual service requires the transportation of Departmental clients or staff, the contractor shall, in addition to the above coverage, secure at its own expense the following coverage:

a.	Automotive Liability (Bodily Injury)	$100,000/$300,000
b.	Automotive Property Damage (to others)	$ 25,000

4. Notwithstanding the information contained above, the Contractor shall indemnify and hold harmless the State of Delaware, the Department and the Division from contingent liability to others for damages because of bodily injury, including death, that may result

from the Contractor's negligent performance under this Contract, and any other liability for damages for which the Contractor is required to indemnify the State, the Department and the Division under any provision of this Contract.

5. The policies required under Attachment L: Section 5 – Contract, Paragraph B must be written to include Comprehensive General Liability coverage, including Bodily Injury and Property damage insurance to protect against claims arising from the performance of the Contractor and the contractor's subcontractors under this Contract and Medical/Professional Liability coverage when applicable.
6. The Contractor shall provide a Certificate of Insurance as proof that the Contractor has the required insurance. The certificate shall identify the Department and the Division as the "Certificate Holder" and shall be valid for the contract's period of performance as detailed in Attachment L, Section L.5 – Standard DHSS Contract, Paragraph A 2.
7. The Contractor acknowledges and accepts full responsibility for securing and maintaining all licenses and permits, including the Delaware business license, as applicable and required by law, to engage in business and provide the goods and/or services to be acquired under the terms of this Contract. The Contractor acknowledges and is aware that Delaware law provides for significant penalties associated with the conduct of business without the appropriate license.
8. The Contractor agrees to comply with all State and federal licensing standards and all other applicable standards as required providing services under this Contract, to assure the quality of services provided under this Contract. The Contractor shall immediately notify the Department in writing of any change in the status of any accreditations, licenses or certifications in any jurisdiction in which they provide services or conduct business. If this change in status regards the fact that its accreditation, licensure, or certification is suspended, revoked, or otherwise impaired in any jurisdiction, the Contractor understands that such action may be grounds for termination of the Contract.
    a. If a contractor is under the regulation of any Department entity and has been assessed Civil Money Penalties (CMPs), or a court has entered a civil judgment against a Contractor in a case in which DHSS or its agencies was a party, the Contractor is excluded from other DHSS contractual opportunities or is at risk of contract termination in whole, or in part, until penalties are paid in full or the entity is participating in a corrective action plan approved by the Department.
    b. A corrective action plan must be submitted in writing and must respond to findings of non-compliance with federal, State, and Department requirements. Corrective action plans must include timeframes for correcting deficiencies and must be approved, in writing, by the Department.
    c. The Contractor will be afforded a 30-day period to cure non-compliance with Section 8(a). If, in the sole judgment of the Department, the Contractor has not made satisfactory progress in curing the infraction(s) within the aforementioned thirty (30) days, then the Department may immediately terminate any and/or all active contracts.
9. Contractor agrees to comply with all the terms, requirements and provisions of the Civil Rights Act of 1964, the Rehabilitation Act of 1973 and any other federal, state, local or any other anti discriminatory act, law, statute, regulation or policy along with all amendments and revision of these laws, in the performance of this Contract and will not discriminate against any applicant or employee or service recipient because of race,

creed, religion, age, sex, color, national or ethnic origin, disability or any other unlawful discriminatory basis or criteria.

10. The Contractor agrees to provide to the Divisional Contract Manager, on an annual basis, if requested, information regarding its client population served under this Contract by race, color, national origin or disability.
11. This Contract may be terminated in whole or part:
    a. by the Department upon five (5) calendar days written notice for cause or documented unsatisfactory performance,
    b. by the Department upon fifteen (15) calendar days written notice of the loss of funding or reduction of funding for the stated Contractor services as described in Appendix B,
    c. by either party without cause upon thirty (30) calendar days written notice to the other Party, unless a longer period is specified in Appendix A.

    In the event of termination, all finished or unfinished documents, data, studies, surveys, drawings, models, maps, photographs, and reports or other material prepared by Contractor under this contract shall, at the option of the Department, become the property of the Department.

    In the event of termination, the Contractor, upon receiving the termination notice, shall immediately cease work and refrain from purchasing contract related items unless otherwise instructed by the Department.

    The Contractor shall be entitled to receive reasonable compensation as determined by the Department in its sole discretion for any satisfactory work completed on such documents and other materials that are usable to the Department. Whether such work is satisfactory and usable is determined by the Department in its sole discretion.

    Should the Contractor cease conducting business, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or assets, or shall avail itself of, or become subject to any proceeding under the Federal Bankruptcy Act or any other statute of any state relating to insolvency or protection of the rights of creditors, then at the option of the Department, this Contract shall terminate and be of no further force and effect. Contractor shall notify the Department immediately of such events.

12. Any notice required or permitted under this Contract shall be effective upon receipt and may be hand delivered with receipt requested or by registered or certified mail with return receipt requested to the addresses listed below. Either Party may change its address for notices and official formal correspondence upon 5 days written notice to the other.

    To the Division at:

    _____

    _____

    _____

    To the Contractor at:

    _____

    _____

    _____

13. In the event of amendments to current federal or State laws which nullify any term(s) or provision(s) of this Contract, the remainder of the Contract will remain unaffected.
14. This Contract shall not be altered, changed, modified or amended except by written consent of all Parties to the Contract.
15. The Contractor shall not enter into any subcontract for any portion of the services covered by this Contract without obtaining prior written approval of the Department. Any such subcontract shall be subject to all the conditions and provisions of this Contract. The approval requirements of this paragraph do not extend to the purchase of articles, supplies, equipment, rentals, leases and other day-to-day operational expenses in support of staff or facilities providing the services covered by this Contract.

This entire Contract between the Contractor and the Department is composed of:

This RFP

Contractor's Proposal

Attachments A – V

16. This Contract shall be interpreted and any disputes resolved according to the Laws of the State of Delaware. Except as may be otherwise provided in this contract, all claims, counterclaims, disputes and other matters in question between the Department and Contractor arising out of or relating to this Contract or the breach thereof will be decided by arbitration if the parties hereto mutually agree, or in a court of competent jurisdiction within the State of Delaware.
17. In the event Contractor is successful in an action under the antitrust laws of the United States and/or the State of Delaware against a Contractor, supplier, subcontractor, or other party who provides particular goods or services to the Contractor that impact the budget for this Contract, Contractor agrees to reimburse the State of Delaware, Department of Health and Social Services for the pro-rata portion of the damages awarded that are attributable to the goods or services used by the Contractor to fulfill the requirements of this Contract. In the event Contractor refuses or neglects after reasonable written notice by the Department to bring such antitrust action, Contractor shall be deemed to have assigned such action to the Department.
18. Contractor covenants that it presently has no interest and shall not acquire any interests, direct or indirect, that would conflict in any manner or degree with the performance of this Contract. Contractor further covenants that in the performance of this contract, it shall not employ any person having such interest.
19. Contractor covenants that it has not employed or retained any company or person who is working primarily for the Contractor, to solicit or secure this agreement, by improperly influencing the Department or any of its employees in any professional procurement process; and, the Contractor has not paid or agreed to pay any person, company, corporation, individual or firm, other than a bona fide employee working primarily for the Contractor, any fee, commission, percentage, gift or any other consideration contingent upon or resulting from the award or making of this agreement. For the violation of this provision, the Department shall have the right to terminate the agreement without liability and, at its discretion, to deduct from the contract price, or otherwise recover, the full amount of such fee, commission, percentage, gift or consideration.
20. The Department shall have the unrestricted authority to publish, disclose, distribute and otherwise use, in whole or in part, any reports, data, or other materials prepared under this Contract. Contractor shall have no right to copyright any material produced in whole or in part under this Contract. Upon the request of the Department, the Contractor shall execute additional documents as are required to assure the transfer of such copyrights to the Department.

    If the use of any services or deliverables is prohibited by court action based on a U.S. patent or copyright infringement claim, Contractor shall, at its own expense, buy for the Department the right to continue using the services or deliverables or modify or replace the product with no material loss in use, at the option of the Department.
21. Contractor agrees that no information obtained pursuant to this Contract may be released in any form except in compliance with applicable laws and policies on the

confidentiality of information and except as necessary for the proper discharge of the Contractor's obligations under this Contract.

22. Waiver of any default shall not be deemed to be a waiver of any subsequent default. Waiver or breach of any provision of this Contract shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of the Contract unless stated to be such in writing, signed by authorized representatives of all parties and attached to the original Contract.
23. If the amount of this contract listed in Paragraph C.2 is over $25,000, the Contractor, by their signature in Section E, is representing that the Firm and/or its Principals, along with its subcontractors and assignees under this agreement, are not currently subject to either suspension or debarment from Procurement and Non-Procurement activities by the Federal Government.

C. Financial Requirements

1. The rights and obligations of each Party to this Contract are not effective and no Party is bound by the terms of this Contract unless, and until, a validly executed Purchase Order is approved by the Secretary of Finance and received by Contractor, *if required by the State of Delaware Budget and Accounting Manual, and all policies and procedures of the Department of Finance have been met*. The obligations of the Department under this Contract are expressly limited to the amount of any approved Purchase Order. The State will not be liable for expenditures made or services delivered prior to Contractor's receipt of the Purchase Order.
2. Total payments under this Contract shall not exceed $ _____ in accordance with the budget presented in Attachment K. Payment will be made upon receipt of an itemized invoice from the Contractor in accordance with the payment schedule, if any. The contractor or Contractor must accept full payment by procurement (credit) card and or conventional check and/or other electronic means at the State's option, without imposing any additional fees, costs or conditions. Contractor is responsible for costs incurred in excess of the total cost of this Contract and the Department is not responsible for such costs.
3. The Contractor is solely responsible for the payment of all amounts due to all subcontractors and suppliers of goods, materials or services which may have been acquired by or provided to the Contractor in the performance of this Contract. The Department is not responsible for the payment of such subcontractors or suppliers.
4. The Contractor shall not assign the Contract or any portion thereof without prior written approval of the Department and subject to such conditions and revisions as the Department may deem necessary. No such approval by the Department of any assignment shall be deemed to provide for the incurrence of any obligations of the Department in addition to the total agreed upon price of the Contract.
5. Contractor shall maintain books, records, documents and other evidence directly pertinent to performance under this Contract in accordance with generally accepted accounting principles and practices. Contractor shall also maintain the financial information and data used by Contractor in the preparation of support of its bid or proposal. Contractor shall retain this information for a period of 5 years from the date services were rendered by the Contractor. Records involving matters in litigation shall be retained for one (1) year following the termination of such litigation. The Department shall have access to such books, records, documents, and other evidence for the

purpose of inspection, auditing, and copying during normal business hours of the Contractor after giving reasonable notice. Contractor will provide facilities for such access and inspection.

6. The Contractor agrees that any submission by or on behalf of the Contractor of any claim for payment by the Department shall constitute certification by the Contractor that the services or items for which payment is claimed were actually rendered by the Contractor or its agents, and that all information submitted in support of the claims is true, accurate, and complete.
7. The cost of any Contract audit disallowances resulting from the examination of the Contractor's financial records will be borne by the Contractor. Reimbursement to the Department for disallowances shall be drawn from the Contractor's own resources and not charged to Contract costs or cost pools indirectly charging Contract costs.
8. When the Department desires any addition or deletion to the deliverables or a change in the services to be provided under this Contract, it shall so notify the Contractor. The Department will develop a Contract Amendment authorizing said change. The Amendment shall state whether the change shall cause an alteration in the price or time required by the Contractor for any aspect of its performance under the Contract. Pricing of changes shall be consistent with those prices or costs established within this Contract. Such amendment shall not be effective until executed by all Parties pursuant to Paragraph B 14.

D. Miscellaneous Requirements

1. If applicable, the Contractor agrees to adhere to the requirements of DHSS Policy Memorandum # 46, (PM #46, effective 3/11/05), and divisional procedures regarding the reporting and investigation of suspected abuse, neglect, mistreatment, misappropriation of property and significant injury of residents/clients receiving services, including providing testimony at any administrative proceedings arising from such investigations. The policy and procedures are included as Appendix _____ to this Contract. It is understood that adherence to this policy includes the development of appropriate procedures to implement the policy and ensuring staff receive appropriate training on the policy requirements. The Contractor's procedures must include the position(s) responsible for the PM46 process in the provider agency. Documentation of staff training on PM46 must be maintained by the Contractor.
2. The Contractor, including its parent company and its subsidiaries, and any subcontractor, including its parent company and subsidiaries, agree to comply with the provisions of 29 Del. Code, Chapter 58: "Laws Regulating the Conduct of Officers and Employees of the State," and in particular with Section 5805 (d): "Post Employment Restrictions."
3. When required by Law, Contractor shall conduct child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564. Contractor shall not employ individuals with adverse registry findings in the performance of this Contract.
4. If applicable, the Contractor agrees to adhere to the requirements of DHSS Policy Memorandum # 40 (PM #40, effective 3/10/2008), and divisional procedures regarding conducting criminal background checks and handling adverse findings of the criminal background checks. The Criminal Background Check Instructions are included in section 4 of this attachment. It is understood that adherence to this policy includes the

development of appropriate procedures to implement the policy and ensuring staff receive appropriate training on the policy requirements. The Contractor's procedures must include the title of the position(s) responsible for the PM40 process in the contractor's agency.

5. If applicable, the Contractor agrees to adhere to the requirements of DHSS Policy Memorandum # 36 (PM #36, effective 9/24/2008), and divisional procedures regarding minimal requirements of contractors who are engaging in a contractual agreement to develop community based residential arrangements for those individuals served by Divisions within DHSS. This policy and procedure are included as Appendix _____ to this Contract. It is understood that adherence to this policy includes individuals/entities that enter into a contractual arrangement (contractors) with the DHSS/Division to develop a community based residential home(s) and apartment(s). Contractors shall be responsible for their subcontractors' adherence with this policy and related protocol(s) established by the applicable Division.
6. All Department campuses are tobacco-free. Contractors, their employees and sub-contractors are prohibited from using any tobacco products while on Department property. This prohibition extends to personal vehicles parked in Department parking lots.
7. The Contractor must follow all Federal and State laws regarding Social Security registration and legal work status of all staff employed or contracted by contractors and any other applicable laws and regulations.

E. Authorized Signatures:

For the Contractor:

_____
Name
Secretary

_____
Title

_____
Date

For the Department:

_____
Rita M. Landgraf

_____
Date

For the Division:

_____
Name
Director

_____
Date

L.6 Criminal Background Check Instructions

Criminal Background Check Instructions

Contractor staff is required to request their own criminal history. For privacy reasons, the SBI and FBI will not mail the results to anyone except the requestor, so the results must be delivered to the DHSS Security Manager at the Biggs Data Center in a sealed envelope. Costs will be borne by the contractor.

1. Visit one of the State Police locations listed on the next page. **Note:** For the New Castle and Sussex locations, appointments may take up to six weeks to schedule.
2. Complete a SBI Personal Criminal History authorization form.
3. Present valid government-issued photo identification, such as a driver's license.
4. The State fee is $45 and the federal check fee is $10, payable by cash or debit/credit card. (No personal checks).
5. The State Police will require you to fill out an FBI fingerprint card, which they will return to you after you have completed the fingerprint process.
6. Complete and sign the FBI Applicant Information Form to request the national record check. The form can be found online at http://www.fbi.gov/about-us/cjis/background-checks/applicant-information-form
7. Mail the Cover Letter and fingerprint card, along with an $18 processing fee, payable by money order, certified check, or credit card. The FBI turnaround time is 3-6 weeks.
8. When you receive your reports at your home address, **DO NOT OPEN THE ENVELOPES**. If you break the seal on the envelopes, you will be responsible to go through the process again at your own expense.
9. Either hand-deliver or mail the **SEALED** FBI and SBI envelopes to:

   DHSS Security Manager
   1901 N DuPont Highway
   Biggs Data Center
   New Castle, DE 19720

   Mark envelopes as **CONFIDENTIAL**.

The results of the criminal background check will be reviewed and kept completely confidential. The total cost is $73.

New Castle County	Kent County (Primary Facility)	Sussex County
State Police Troop 2 100 LaGrange Ave Newark, DE 19702 (Between Rts. 72 and 896 on Rt. 40) **** By appointment only** To schedule an appointment: Phone: 302-739-2528 or Toll Free 1-800-464-4357	**State Bureau of Identification** 655 Bay Road Blue Hen Mall and Corporate Center Suite 1B Dover, DE 19903 Customer Service: 302-739-5871 **** Walk-ins accepted** Hours of Operation Monday 9AM – 7PM Tuesday – Friday 9AM – 3PM	**State Police Troop 4** S DuPont Hwy & Shortly Rd Georgetown, DE 19947 (Across from DelDOT & State Service Center) **** By appointment only (every other Wednesday)** To schedule an appointment: Phone: 302-739-2528 or Toll Free 1-800-464-4357

L.7 Performance Based Contracts and Damages for Systems Contractors

L.7.1 Performance Standards and Quality Management

The Prime will implement and operate an on-going quality management program in accordance with the project quality management plan which includes statistical measurement and reporting of key performance standards and key performance indicators (KPIs). During the course of the Contract, performance standards and KPIs will be measured and reviewed by DHSS using the Performance Monitoring System and will actively participate with the Prime to approve the results, request corrective action, or assess damages as necessary.

L.7.2 Performance Based Contracts and Damages for Vendors

L.7.2.1 Approach to Reporting

Performance standards are being implemented to improve the quality of Contract performance, provide documented performance levels in critical areas of the DMES's functionality, architecture and operations and to improve DHSS's contract management oversight and capabilities.

Each Performance Standard will be measured against a set of metrics or KPIs as established through negotiation between DHSS and the Prime. The Prime in cooperation with its subcontractors will provide systems, operations, and performance monitoring tools and an automated method for monitoring the DMES's performance. All metrics used in providing reports of quality measurement required by DHSS shall be at no additional cost to the State. DHSS will have real time access to all monitoring tools, processes, and reporting.

Quality measures will be reported using automated tools that provide flexibility and adaptability. A rules-based engine, or similar technology application, will be used to facilitate changes to quality measures as required by DHSS during the Operations Phase. The Performance Monitoring System results will be posted on the public web portal real time or as they are available to support performance measurements

An independent, accredited auditing firm or qualified third party approved by DHSS may review all audit reports on a schedule defined by DHSS

L.7.2.2 Actual and Liquidated Damages

Damage may be sustained by the State in the event that the Prime fails to meet the requirements of this Contract. In the event of default or the inability to maintain minimum standards as determined by DHSS, the Prime agrees to pay the State for the actual cost of damages or the specifically outlined sums as liquidated damages as defined in this RFP. Liquidated damages are considered compensation for increased Contract management cost. Liquidated damages are for those losses that DHSS cannot reasonably ascertain a specific dollar value. Liquidated damages will not exceed 2.5 times the Prime's monthly invoice to DHSS.

L.7.2.3 Right to Assess Damages

DHSS will assess damages based on its assessment of the Prime's success in meeting required performance standards. If damages can be measured in actual cost, they are referred to as actual damages. If the damages are difficult to measure or cannot be measured in actual cost, they are referred to as liquidated damages. The Prime must agree to or provide evidence

acceptable to DHSS to challenge the reimbursement to the State for actual damages or the amounts set forth as liquidated damages within 30 days.

DHSS will notify the Prime in writing of the proposed damage assessment. The amounts due to DHSS as actual damages may be deducted from any fees or other compensation payable to the Prime or DHSS may require the Prime to remit the damages within 30 days following the notice of assessment or resolution of any dispute. At DHSS's option, DHSS may obtain payment of assessed damages through one or more claims upon any irrevocable letter of credit furnished by the Prime.

L.7.2.4 Dispute Resolution Process for Damage Assessments

DHSS expects that any disputes arising under the Contract will be approached first through negotiations with State Management and second through an appeal to the Director of DHSS or his or her designee. Legal action should only be initiated if all of these mechanisms fail.

The venue for any formal legal proceeding shall lie within the State of Delaware. Pending final determination of any dispute, the Prime shall proceed diligently with performance of the Contract and in accordance with the direction of DHSS.

L.7.2.5 Performance Measures, Service Level Agreements, and Damages

Performance Standards:

1. The Prime and its vendors will be subject to meeting performance standards with a comparison of performance against those standards made periodically at a frequency specified by DHSS. DHSS has the right to change the frequency based on Vendor performance or DHSS policy.
2. The Prime and its vendors must have processes in place to monitor and self report against all performance standards
3. It is possible for a performance failure to occur that is closely related to other specified performance standards but not included in this RFP A performance failure that occurs and is not contemplated as part of this RFP or the resulting Contract will be handled in the following manner:
    a. DHSS will notify the Prime of the failure
    b. The Prime will have 10 workdays to submit to DHSS a corrective action plan to address the failure
    c. Should the corrective action plan or work plan be rejected, DHSS will assess liquidated damages of $100 per calendar day for every day a DHSS acceptable corrective action plan delivery is delayed
    d. Upon receipt of a DHSS accepted corrective action plan DHSS will monitor the implementation of the plan
    e. Should the same error or performance failure reoccur the Prime will be assessed liquidated damages of $1,000 for each week or part of a week in which the failure occurs up to a maximum of $52,000 per year per occurrence

The following tables provide Master Service Level Agreements by business area.

L.7.2.6 Quality Management Performance Standards

Quality Management Program		
#	**Performance Requirement**	**Damages**
1.	The Prime in cooperation with its vendors will implement and operate an on-going quality management program at no additional cost to DHSS for measuring and reporting performance. Under the Primes initiative or when requested by DHSS, corrective action plans will be documented and implemented.	The consequences for failure to meet the standard will equal a 1.5% reduction on the Prime's monthly invoice.
2.	The Prime in cooperation with its vendors will implement a Performance Monitoring System at no additional cost to provide DHSS a manual or automated method and other tools used to provide reporting of the quality and performance measurements agreed upon by DHSS and the Prime. The Prime must document and publish desk level procedures and report results of quality analysis.	The consequences for failure to meet any part of the standard will equal a 1.5% reduction on the Prime monthly invoice.
3.	DHSS will specify standard performance measurement reports to be prepared by the Prime's Quality Management Program (QMP) and Performance Monitoring System including an online dashboard displaying metrics as defined by DHSS. The reports must be posted in a central location specified by DHSS with alerts as reports are updated or posted. DHSS must have access to the data repository to run queries and produce independent audit reports.	The consequences for failure to meet any part of the standard will equal a 1.5% reduction on the Prime monthly invoice.
4.	DHSS must approve the audit method and reserves the right to audit reports and/or conduct audits at a duration and schedule based on DHSS policy and discretion. DHSS may perform unscheduled audits. DHSS may also have a qualified third party perform audits of the Prime's audit.	The consequences for failure to meet the standard will equal a 1.5% reduction on the Prime monthly invoice.
5.	The Quality Assurance (QA) Unit, in compliance with the QMP, will create an annual audit plan to include an annual audit schedule. The audit plan will address each of the QA processes and tasks identified in the QMP. The audit schedule will contain a work break down structure, detailing the work samples or sample areas in which reviews will be conducted, and milestone dates. The annual audit plan must be submitted to DHSS annually.	The damages for failure to meet the standard will equal a 2.5% reduction in the Prime's monthly invoice.

L.7.2.7 Implementation and System Architecture Performance Standards

Implementation and System Architecture		
#	Performance Requirement	Damages
1.	**Start Date** Establish measurable goals for the timely and successful implementation of the DMES by July 1, 2016 using management best practices including the Project Management Body of Knowledge® (PMBOK) and Capability Maturity Model Integration (CMMI) as approved by DHSS. Failure to implement the DMES by July 1, 2016 based on DHSS standards and approval will constitute failure to substantially perform and will result in the assessment of liquidated damages. Fully implement means to begin processing correctly all claim types, claims adjustments, and other financial transactions; maintaining all system files; producing all required reports; and performing all other Prime responsibilities specified in this RFP.	The damages for failure to meet any part of the standard will equal liquidated damages of $250,000 per week of delay.
2.	The Prime is expected to identify any MITA business processes that are at Level 1 or Level 2 in maturity and to propose a roadmap to progressively move to Level 3 or above during the Design Phase. Thereafter, the roadmap will be reviewed and updated annually by the Prime and submitted to DHSS for review no later than January 31, of each calendar year. Level 3 requires that States begin to develop and share sets of reusable business services using the MITA defined interface within a service-oriented architecture (SOA).	The damages for failure to meet the standard will equal a $5,000 reduction in the Prime's monthly invoice until the roadmap is submitted and approved by DHSS.
3.	The system must employ an SOA and Enterprise Service Bus (ESB) incorporating all elements outlined in SOA, Attachment C.3.7.	The damages for failure to meet the standard will equal a 10% reduction in the Prime's monthly invoice.

L.7.2.8 Certification and HIPAA Compliance Performance Standards

Certification and HIPAA Compliance		
#	Performance Requirement	Damages
1.	Failure to receive Certification at the earliest certification schedule approved by CMS and DHSS retroactive to implementation or achieve HIPAA compliance will constitute failure to substantially perform and will result in the assessment of actual damages. The certification date which is determined by CMS is not appealable and cannot be challenged by the Prime.	The Consequences for failure to meet the standard will equal the difference between the maximum allowable FFP and that actually received by the State for the operation of the DMES as required by certification standards that is attributable to performance or non-performance by the Prime.
2.	All requirements under the CMS "Enhanced Funding Requirements: Seven Conditions and Standards" must be met in order to receive enhanced funding. The Prime will be responsible for meeting these certification requirements.	For failure to meet the "Enhanced Funding Requirements: Seven Conditions and Standards" during the Certification Phase, the Prime will pay to the State any federal dollar difference between the maximum allowable enhanced FFP and the amount actually received by the DHSS, plus any fines or penalties against the State. These monies shall be withheld from monies payable to the Prime until all such damages are satisfied. The Prime will also pay liquidated damaged of $10,000 per calendar day for failure to achieve CMS Certification until Certification is met.
3.	Title 42 U.S.C. 1996 1902(a)(3)(B) provides 75% FFP for operation of a mechanized claims payment and information retrieval system approved by CMS. Enhanced FFP of 90% is available for MMIS related development costs prior approved by CMS in the State's Advanced Planning Document (APD) and at Contract signing. The Delaware MMIS must, throughout the Contract period, meet all certification and re-certification requirements and maintain HIPAA compliance as established by CMS.	For any violation or loss of federal certification, the Prime will pay to the State any federal dollar difference between the maximum allowable enhanced FFP and the amount actually received by DHSS. All FFP penalty claims assessed by CMS shall

Certification and HIPAA Compliance		
#	Performance Requirement	Damages
		be withheld from monies payable to the Prime until all such damages are satisfied.
4.	The selected vendor must certify compliance with HIPAA regulations and requirements as described in Department of Health and Human Services, Office of the Secretary, 45 CFR Parts 160, 162 and 164, as well as all HIPAA requirements related to privacy, security, transaction code sets (where applicable) and medical provider enumeration.	For any HIPAA non-compliance that results in loss of federal certification, the Prime will pay to the State any federal dollar difference between the maximum allowable enhanced FFP and the amount actually received by DHSS, plus any actual damages incurred due to HIPAA non-compliance. All FFP penalty claims assessed by CMS shall be withheld from monies payable to the Prime until all such damages are satisfied.
5.	Develop a HIPAA risk management plan to eliminate or mitigate HIPAA risks. A HIPAA risk assessment must be conducted annually and the results reported to DHSS in a formal report no later than the 30th day of January for each calendar year. .	The liquidated damages will be $1,000 for each business day the deliverable is late or unacceptable.

L.7.2.9 Staffing and Key Personnel Performance Requirements

Staffing and Key Personnel		
#	Performance Requirement	Damages
1.	Named Staff Positions that are designated as Named Staff in the Bidder's proposal shall be delivered as bid unless a change is approved in writing by DHSS. DHSS must approve all Named Staff in the proposal and Named Staff will not change without DHSS prior approval.	DHSS may reduce payments to the Contractor in the amount equal to the vacated position's pay rate for the time period the position is vacant.
2. .	Named Staff Vacancy Positions that are designated as Named Staff shall not remain vacant for more than 30 calendar days. Named Staff positions shall not be filled with employees who will fulfill the roles and responsibilities of the position in a temporary capacity and/or maintain responsibilities for another position. DHSS must approve all Named replacement staff as needed. Named replacement staff must meet the minimum knowledge, skills, and abilities of their predecessor.	DHSS may reduce payments to the Contractor in the amount equal to the vacated position's pay rate for the time period the position is vacant.

Staffing and Key Personnel		
#	Performance Requirement	Damages
3.	Categorized Staff No less qualified Categorized Staff will be maintained as specified in the Bidder's proposal and staffing vacancies must be filled within 30 days of the date the initial vacancy occurred. Staff must become proficient in DHSS and Delaware program knowledge. Staffing levels and rate of pay must meet DHSS requirements and approval.	DHSS may reduce payments to the Contractor in the amount equal to the vacated position's pay rate for the time period the position is vacant.

L.7.2.10 Call Center Operations Performance Requirements

Call Center Operations		
#	Performance Requirement	Damages
1.	Availability Staff operators must be available to answer calls in the Provider and Pharmacy Call Centers from 8:00 a.m. to 5:00 p.m., ET, Monday through Friday. The performance standard shall be measured monthly and will be reviewed with DHSS in detail as a part of the monthly audit.	The damages for failure to meet the standard will equal a 2.5% reduction in the Prime's monthly invoice.
2.	Average Speed to Answer (ASA) Answer within 30 seconds 80% or more of provider and client calls. Answer within 30 seconds 80% of client eligibility calls. The performance standard will be measured monthly and will be reviewed with DHSS in detail as part of the monthly audit. "Answer" shall mean for each caller who elects to speak to a live representative.	The damages for failure to meet the standard will equal a 2.5% reduction in the Prime's monthly invoice.
3.	Call Center Phone Inquiries Respond to telephone inquiries within 2 business days with an interim answer and a final response within 14 calendar days when follow-up is needed.	The damages for failure to meet the standard will equal a 2.5% reduction in the Prime's monthly invoice.
4.	Accurate Response to Inquiries Customer Service Representative Accuracy rate must be 90% or higher. The performance standard will be measured monthly and will be reviewed with DHSS in detail as part of the monthly audit.	The damages for failure to meet the standard will equal a 2.5% reduction in the Prime's monthly invoice.
5.	Call Abandonment Rate The performance standard for call abandonment as determined by the State will be measured monthly and will be reviewed with DHSS as part of the monthly audit. A call will be considered "abandoned" if the caller elects an option and is either not permitted access to that option or disconnects from the system.	The damages for failure to meet the standard will equal a 2% reduction in the Prime's monthly invoice.

Call Center Operations		
#	Performance Requirement	Damages
6.	Busy Out/Blocked Call Rate Busy Out/Blocked Call rate must be 5% or less. The performance standard will be measured monthly and will be reviewed with DHSS as part of the monthly audit. A Busy Out/Blocked Call is a call made by a caller, but was not allowed into the system.	The damages for failure to meet the standard will equal a 1% reduction in the Prime's monthly invoice.
7.	On Hold Time On Hold Time rate must be less than one minute 95% of the time. The performance standard will be measured monthly and will be reviewed with DHSS as part of the monthly audit. The On Hold Time must be one minute or less without response by a human operator to a caller's inquiry.	The damages for failure to meet the standard will equal a 1% reduction in the Prime's monthly invoice.
8.	Timely Response to Written Correspondence 100% of all written correspondence (non-electronic) will be responded to and mailed to the correct provider or client with at least an interim answer within 5 business days and a final response within 14 calendar days from when the correspondence was received. The performance standard will be measured monthly and will be reviewed with DHSS as part of the monthly audit.	The damages for failure to meet the standard will equal a 1.0% reduction in the Prime's monthly invoice.
9.	Call Center Reporting The Contractor is responsible for providing statistics for up-to-date monitoring of the call center activities and quarterly summaries of historical activity that helps to determine highest call volume for any time of day, week, or month including call type and user ID. The Contractor shall deliver to the State a monthly report on Provider Relations Call Center activity by no later than the fifth business day beginning that month. The Contractor may also be called upon by the State to produce daily, weekly call center activity reports as necessary.	The damages for failure to meet the standard will equal liquidated damages of $500 per workday for each workday the Prime fails to meet this requirement.

L.7.2.11 Provider Enrollment Performance Requirements

Provider Enrollment		
#	Performance Requirement	Damages
1.	Process provider enrollment application within ten (10) business days from receipt.	The damages for failure to meet the standard will equal $100 per instance.
2.	Enroll providers in the Delaware Medicaid program using the rules, steps, and work flow process approved by the State. Providers must be fully enrolled and activated within two (2) workdays of completion of all requirements set by the State:	The damages for failure to meet the standard will equal $100 per instance.

Provider Enrollment		
#	Performance Requirement	Damages
3.	Process provider file updates and recertification materials within ten (10) business days of receipt.	The damages for failure to meet the standard will equal $100 per instance.
4.	Image all provider enrollment/re-enrollment applications and supporting documentation within two (2) workdays of completion of all enrollment requirements. Imaging of current hard copy documents from provider file is required at the time of reenrollment;	The damages for failure to meet the standard will equal $100 per instance.
5.	Document enrollments and send notice of enrollment and provider manuals to enrolled providers within five (5) workdays of completion of enrollment	The damages for failure to meet the standard will equal $100 per instance.
6.	Organize and maintain all paper provider files in provider number order. The Contractor is required to keep all provider files current, and to file all items within two (2) workdays	The damages for failure to meet the standard will equal $100 per instance.

L.7.2.12 AVRS Performance Requirements

Automated Voice Response and Eligibility Verification System		
#	Performance Requirement	Damages
1.	The Prime shall provide a backup system to assure that downtime is limited to no more than 30 continuous minutes.	The damages for failure to meet the standard will equal a $1,000 reduction in the Prime's monthly invoice.
2.	The Prime shall provide sufficient in-bound access lines for the EVS so that providers do not encounter busy conditions at least 95% of the time.	The damages for failure to meet the standard will equal a $1,000 reduction in the Prime's monthly invoice.
3.	Initial response must be within 4 seconds 95% of the time for AVR voice responses and electronic EVS screen responses	The damages for failure to meet the standard will equal a $1,000 reduction in the Prime's monthly invoice.
4.	Commercial eligibility vendors will have 99% of their transactions responded to without a time-out.	The damages for failure to meet the standard will equal a $1,000 reduction in the Prime's monthly invoice.
5.	Timely Response to Electronic Correspondence 100% of all electronic correspondence including email, faxes, web portal inbox, and other electronic responses will be sent to the correct provider or client with an interim answer within 2 business days and a final response within 14 calendar days from when the electronic correspondence was received. The performance standard will be measured monthly and will be reviewed with DHSS as part of the monthly audit.	The damages for failure to meet the standard will equal a 1% reduction in the Prime's monthly invoice.

Automated Voice Response and Eligibility Verification System		
#	Performance Requirement	Damages
6.	Accurate Response Maintain 100% accuracy rate for all provider and client correspondence (written and electronic) in accordance with State law and regulations. The performance standard will be measured monthly and will utilize a statistically significant sample of open correspondence for DHSS review as part of the monthly audit.	The damages for failure to meet the standard will equal a 1% reduction in the Prime's monthly invoice.

L.7.2.13 Claims Processing Performance Requirements

Claims Processing		
#	Performance Requirement	Damages
1.	Pay or deny claims with 98% accuracy as measured over a time period defined by DHSS.	The damages for failure to meet the standard will equal $1,000 per occurrence and the Prime shall be liable for any overpayment or duplicate payment.
2.	Pharmacy Point of Sale (POS) Claims The Prime must ensure that the Pharmacy POS System meets all performance standards as outlined in this document. The Pharmacy POS System provides access to the pharmacist filling the client prescription to both adjudication and Pro-DUR information.	If an overpayment or duplicate payment is made to a provider and that payment is the result of a failure of the Prime to maintain the Pharmacy POS System according to the Contract requirements, then the Prime shall be liable for the overpayment or duplicate payment for which full recovery cannot be made.
3.	Claim Turnaround Time – Clean Claims Contractor must process 100% of clean claims including paper and electronic claims paid or denied within the next payment processing cycle. A clean claim is one that can be processed without obtaining additional information from the provider of the service or from a third party. The calculation for the Claim Turnaround Time percentage will be measured on the percentage of all clean claims processed within the number of working days from the date of receipt as listed above. The performance standard does not apply with respect to a claim during the period the claim is suspended for information outside the Prime's claims processing system or scope of responsibility or control.	The damages for failure to meet the standard will equal a 2.5% reduction in the Prime's monthly invoice.

Claims Processing		
#	Performance Requirement	Damages
4.	Claim Turnaround Time – Non-Clean Claims Adjudicate 90% of corrected non-clean/suspended claims within two payment processing cycles and 99% within three payment cycles or 24 calendar days of the date of correction.	The damages for failure to meet the standard will equal a 2.5% reduction in the Prime's monthly invoice.
5.	Claim Turnaround Time – All Claims Ninety-nine percent (99%) of all claims, including paper and electronic claims, must be paid or denied within 30 calendar days of receipt unless specified differently by DHSS. The calculation for the Claim Turnaround Time percentage will be measured monthly on the percentage of all claims processed within the number of working days from the date of receipt as listed above.	The damages for failure to meet the standard will equal a 2.5% reduction in the Prime's monthly invoice.
6.	Nursing Home and Waiver Claims Process all LTC facility and all waiver claims in the next claim cycle after receipt.	The damages for failure to meet the standard will equal a 2.5% reduction in the Prime's monthly invoice.
7.	Provider-Initiated Adjustments Process all provider-initiated adjustments within 2 days of receipt.	The damages for failure to meet the standard will equal $100 per instance.
8.	Claim Control Number Assign a unique control number to every claim, attachment, and adjustment upon receipt at the FA's site.	The damages for failure to meet the standard will equal $100 per instance.
9.	Electronic Claims Load electronically submitted claims to the MMIS within 1 business day of receipt by the FA.	The damages for failure to meet the standard will equal $100 per instance.
10.	Claims Imaging Image every claim and attachment within 1 business day of receipt at the FA's site.	The damages for failure to meet the standard will equal $100 per instance.
11.	Hard-copy Claims Entry Enter all hard-copy claims into the system within 2 business days of receipt.	The damages for failure to meet the standard will equal $100 per instance.
12.	Claim Adjustments Adjustments must be completed within 30 days of submission except in those cases where DHSS approves a longer period.	The damages for failure to meet the standard will equal liquidated damages of $100 per workday per adjustment not processed accurately within 30 days of submission.

L.7.2.14 Mail Room Performance Requirements

Mail Room		
#	Performance Requirement	Damages
1.	Return of hard-copy Claims Return hard-copy claims missing required data to the sender within 2 business days of receipt.	The damages for failure to meet the standard will equal $100 per instance.
2.	Payment Denial Notifications Mail all notifications of payment denial by the FA within 15 calendar days of receipt.	The damages for failure to meet the standard will equal $100 per instance.
3.	Mail applications and renewals, informational brochures, and replacement identification cards within 1 business day of request receipt.	The damages for failure to meet the standard will equal $100 per instance.
4.	Mail 1099 forms by January 31 of each year.	The damages for failure to meet the standard will equal a $1,000 per business day reduction in the Contractor's monthly invoice until the report is corrected.
5.	Send provider enrollment packets within 2 business days of request.	The damages for failure to meet the standard will equal $100 per instance.
6.	Mail Prior Authorization and Drug Prior Authorization Approval, Denial, or Suspended Letters within 1 business day of generation.	The damages for failure to meet the standard will equal $100 per instance.
7.	Before January 1 of each year, families identified during the outreach effort of the previous calendar year will receive their information packets. The packets will include: Letter (generic), Return envelope for the appropriate State Service Center, DHCP/Medicaid application, and a Slim Jim with DHCP program information.	The damages for failure to meet the standard will equal $100 per instance.
8.	Send claim forms and other billing documents to providers within 2 days of request for the forms.	The damages for failure to meet the standard will equal $100 per instance.

L.7.2.15 ARRA Performance Requirements

American Recovery and Reinvestment Act of 2009		
#	Performance Requirement	Damages
9.	Meet all the provisions of the American Recovery and Reinvestment Act (ARRA) Prompt Pay performance requirements.	The damages for failure to meet the standard will equal $100 per instance.

L.7.2.16 Reporting Performance Requirements

Reporting		
#	Performance Requirement	Damages
1.	The Prime shall provide access to the online DMES during off hours and on weekends at no extra charge whenever requested by DHSS at least 48 hours in advance.	The damages for failure to provide access to the DMES will equal $500 per instance.
2.	Produce Management Accounting and Reporting (MAR) Reports as required. DHSS will notify the Contractor if any error in a report is detected and the Contractor will have 5 days to correct the report from the date of DHSS notification. If not corrected in 5 days a penalty of $1,000 a month for each report may be assessed.	The damages for failure to meet the standard will equal a $1,000 reduction in the Contractor's monthly invoice until the report is corrected.
3.	Produce SUR Reports as required. DHSS will notify the Contractor if any error in a report is detected and the Contractor will have 5 days to correct the report from the date of DHSS notification. If not corrected in 5 days a penalty of $1,000 a month for each report may be assessed.	The damages for failure to meet the standard will equal a $1,000 reduction in the Contractor's monthly invoice until the report is corrected.
4.	Reports must consistently meet the design requirements approved by DHSS with 100% accuracy. Accuracy as defined here includes; the completeness and format of data elements, report layout/format, approved media, timeliness of production with respect to schedule, and accuracy of data calculations. DHSS shall notify the Contractor, in writing, of any inaccuracies or discrepancies in reports and the Contractor shall have 3 business days to respond with a solution and 5 business days to correct the problem and meet the reporting accuracy requirements.	The damages for failure to meet the standard for accurate reporting shall be $500 per day for each report identified as inaccurate, from the date of the notification until the date the corrected report is delivered and validated by the State.

L.7.2.17 System Availability Performance Requirements

Systems Availability		
#	Performance Requirement	Damages
1.	The DMAP Website, and other ancillary system components as required by DHSS, must be available 24x7 except for DHSS approved time for system maintenance.	The damages for failure to meet the standard will equal $1,000 per hour after one hour of Prime notification or one hour after any system failure,

Systems Availability		
#	Performance Requirement	Damages
		whichever occurs first.
2.	The Prime must formally request DHSS approval and notify DHSS prior to any scheduled system down time. DHSS will consider any down time not approved by DHSS or any down time where the Prime does not notify DHSS as unscheduled down time.	The damages for failure to meet the approval and notification standards will equal $1,000 per occurrence.
3.	The entire Delaware Medicaid Enterprise System and all ancillary systems must be available at a minimum between the hours of 7:00 a.m. and 7:00 p.m., Monday through Friday.	The damages for failure to meet the system availability standard will equal $1,000 per hour after one hour of Prime notification or one hour after any system failure, whichever occurs first.

L.7.2.18 System Response Time Performance Requirements

System Response Time		
#	Performance Requirement	Damages
1.	The DMES's response times will be measured during normal working hours, which are 7:00 a.m. to 7:00 p.m. ET, Monday through Friday. The Web Portal response times will be measured 24x7 except for DHSS approved time for system maintenance. Other response time requirements are as follows: a. The Prime must provide a system to monitor and report on response times. Time will be measured at DHSS discretion. b. The DMES's Record Search Time must be within 4 seconds for 95% of record searches. Record Search Time is the time elapsed after the search command is entered until the list of matching records appears or loads to completion on the monitor. c. The DME's Record Retrieval Time must be within 4 seconds for 95% of records retrieved. Record Retrieval Time is the time elapsed after the retrieve command is entered until the record data appears or loads to completion on the monitor. d. The DMES's Screen Edit Display Time must be within 2 seconds for 95% of the time. Screen Edit Time is the time elapsed after the last field is filled on the screen with an enter command until all field entries are edited with errors highlighted on the monitor. e. The DME's New Screen/Page Time must be within 2 seconds for 95% of the time. New Screen/Page Time is the time elapsed from the time a new screen is requested until the	The damages for failure to meet the system response time standards in this section will equal $1,000 per hour after one hour of Prime notification or one hour after any system failure, whichever occurs first, up to $40,000 per week.

System Response Time		
#	Performance Requirement	Damages
	data from the screen appears or loads to completion on the monitor. f. The DME's Print Initiation Time must be within 2 seconds for 95% of the time. Print Initiation Time is the time elapsed from the command to print a screen or report until it appears in the appropriate queue. g. Ad hoc and on-demand reports within the timeframes defined by DHSS in the report request, but normally within 5 seconds after the request is initiated 95% of the time. h. The Web Portal Response Time must be within 4 seconds for 99% of the time. Web Portal Response Time is the elapsed time from the command to view a response until the response appears or loads to completion on the monitor. i. The electronic document storage and retrieval repository must be capable of consistently retrieving and storing images within 10 seconds 95% of the time for the most recent 12 months. Each subsequent page of the same document (or a claim and its attachments) must be displayed in one second or less 95% of the time. Image Retrieval Time is the time elapsed after the retrieve command is entered until the image data appears or loads to completion on the monitor.	
2	The Prime shall provide access to the online DMES during off hours and on weekends at no extra charge whenever requested by DHSS at least 48 hours in advance.	The damages for failure to provide access to the Solution will equal $5,000 per instance.

L.7.2.19 System Maintenance and Support Performance Requirements

System Maintenance and Support		
#	Performance Requirement	Damages
1.	Routine Maintenance The Prime will be required to notify DHSS immediately as software errors are discovered. The Prime shall be responsible for "routine" maintenance of the modules and system components at no charge to DHSS and not through the use of the Solution modification change control process. Instead, certain coding changes and Solution errors/defects will be logged and tracked through a "Defect Tracking Log." DHSS will prioritize Priority 1 and Priority 2 errors. The Prime is responsible for resolving all errors within the following timeframes: Priority 1 Errors: Within 24 hours Priority 2 Errors: Within 5 business days Priority 3 Errors: Within an agreed upon schedule between the Prime and DHSS. This will be measured on a schedule defined by DHSS.	The damages for failure to meet the notification standard will equal $1,000 per calendar day from the first documented date of discovery until DHSS notification date. The damages for failure to meet the error standard will equal $1,000 per calendar day for each error not timely resolved. The Prime's performance will be measured by the completeness of the "fix" as measured by DHSS. Payment of any liquidated damages will not relieve the Prime from its obligation to meet the requirements established by the Prime's response to the RFP in regard to the Solution maintenance activities.
2.	Data Maintenance Requests The Prime shall provide support for Solution data maintenance requests, for example: data migration, data compression, and data backup and upkeep; and shall complete data maintenance requests within 24 hours of receipt from DHSS.	The damages for failure to meet the standard will equal $1,000 per business day for each data maintenance request not completed timely.
3.	Modifications, Changes, and Updates The Prime shall provide support for DMES modifications, changes, and updates including: Statement of understanding in writing within 10 business days of receipt of Change Control (CC) Prime must report status of each CC timely and accurately as part of the change control process as required and requested by DHSS CCs must be completed by agreed upon date Updated documentation as specified by DHSS related to CC implementation including but not limited to system, user, training, or other online documentation must be provided to DHSS within 15 calendar days of CC implementation	The damages for failure to meet any part of the standard will equal $1,000 per business day for each occurrence.

System Maintenance and Support		
#	Performance Requirement	Damages
4.	Change Control and Software Releases In accord with the Change Management Plan described in Attachment E.1.2 of this document, the Prime shall adhere to the change control process approved by DHSS for all software and hardware changes All software and hardware releases must be planned and approved by DHSS Release notes must be provided by the Prime upon release approval by DHSS and prior to release implementation	The damages for failure to meet any part of the standard will equal $1,000 per instance per business day the change control and release process is not followed.
5.	General Maintenance tasks include the best practices adopted by the Department of Technology and Information (DTI), through the Technology and Architecture Standards Committee (TASC). The Contractor will develop solutions using architecture, software, and hardware deemed to be in a Standard or Acceptable category by DTI. When an architecture, software, or hardware is moved to a category of discontinue the Contractor must develop a plan to move to a solution considered Standard. DHSS expects contractors to monitor the applicable sections of DTI Enterprise Standards and Policies website and maintain these standards throughout the life of the contract. These standards are applicable to all Information Technology use throughout the State of Delaware.	The damages for failure to meet any part of the standard will equal $1,000 per instance per business day for non-compliance.

L.7.2.20 Business Continuity and Disaster Recovery Performance Requirements

Business Continuity and Contingency Plan (BCCP) and Disaster Recovery Plan		
#	Performance Requirement	Damages
1.	Business Continuity and Contingency Plan (BCCP)/Disaster Recovery (DR) Plan The Contractor must maintain a DHSS approved BCCP Plan and Disaster Recovery Plan. The plan must meet state standards and be The plan must be available to CMS, DHSS, or State auditors at all times. The plan must be updated at least annually and provided to DHSS electronically prior to the end of each Calendar year.	The damages for not correctly maintaining the plan will equal $1,000 per calendar day until it is updated and available to DHSS or State auditors.
2.	Data Protection All current, historical, and archived data, tables, and files in the Solution and ancillary systems must be protected in an offsite location approved by DHSS to mitigate the risk of a natural or man-made disaster.	The damages for failure to meet the Disaster Recovery offsite location standard will equal $10,000 per calendar day for each calendar day the backup site is not fully operational or the current, historical, and archived

Business Continuity and Contingency Plan (BCCP) and Disaster Recovery Plan		
#	Performance Requirement	Damages
		data, tables, and files are not available preventing normal MMIS and ancillary system operation.
3.	Alternative Business Site The Prime must provide an alternate business area site in the event the primary business site becomes unsafe or inoperable.	The damages for failure to meet the Disaster Recovery alternate business area site location will equal $10,000 per calendar day for each calendar day the backup site is not fully operational preventing normal Solution and ancillary system operation.
4.	Resumption of Operations All critical operations must be clearly defined in the Prime's DHSS approved disaster recovery plan and must resume within 5 workdays following a disaster.	The damages for failure to meet the standard will equal $10,000 per calendar day after the initial period following a disaster preventing normal Solution and ancillary operation.
5.	Loss of Online Communications The Prime must have backup procedures and support to accommodate the loss of online communications between the Prime's processing site and the State. These procedures must specify the alternate location for the State to utilize the Solution online system and ancillary systems in the event the Solution and/or ancillary systems are down in excess of 2 business days.	The damages for failure to meet the standard will equal $10,000 per calendar day for each calendar day that an alternate location for the State to utilize the Solution online system and ancillary systems is not made available after 2 business days
6.	Data Backup Backup of all system database tables, data, and files must occur on a daily basis to preserve the integrity of both historical and current data.	The damages for failure to meet the Disaster Recovery backup standards will equal $1,000 per calendar day for each system database table, data, or file not successfully backed up.
7.	Inventory Report The Contractor must supply DHSS an inventory report of all Solution database tables, data, and files backed up and archived. This must be provided every six months or upon DHSS request.	The damages for failure to meet the standard will equal $1,000 per calendar day the inventory report is not available for DHSS review.
8.	Disaster Recovery Demonstration The Contractor must perform an annual disaster recovery demonstration and a review of the disaster recovery backup site, procedures for all offsite storage, and validation of security	The damages for failure to meet the standard will equal $1,000 per calendar day for each calendar day after June 30 that the DR

Business Continuity and Contingency Plan (BCCP) and Disaster Recovery Plan		
#	Performance Requirement	Damages
	procedures, following State DHSS requirements. Demonstration and review must be completed and a report submitted to DHSS within 15 calendar days of the review.	demonstration is not performed or that the completed report is not submitted to the State within 15 calendar days of the review.
9.	The State will be allowed to inspect the disaster recovery backup site and procedures at any time with 24-hour notification.	The damages for failure to meet the standard will equal $1,000 per calendar day for each calendar day the State's request is delayed.
10.	System Back-up Plan must be maintained. The plan must meet state standards and be available to CMS, DHSS, or State auditors at all times. The plan must be updated at least annually and provided to DHSS electronically prior to the end of each Calendar year.	The damages for not correctly maintaining the plan will equal $1,000 per calendar day until it is updated and available to DHSS or State auditors.
11.	The backup site and disaster recovery procedures may be audited by the State, and must be maintained to the State's standards.	The damages for failure to meet the this standard will equal $1,000 per calendar day the State determines the back-up site and disaster recovery procedures are not in compliance with state standards.

L.7.2.21 Banking and Finance Operations Performance Requirements

Banking and Finance Operations		
#	Performance Requirement	Damages
1.	General Financial Responsibilities The Prime will be required to enter into a contract with financial institution(s) to provide banking services. There may be multiple accounts that will be needed, depending on the needs and requirements of the State. The account(s) will be in the State's name and the Prime will be granted authority to operate the account(s) on behalf of the State. The Prime will be required to sign a contract/agreement which would include the parties to the account (that is, the State, the Prime, and the financial institution) as well as any other required documents in order to establish and manage the account(s) on behalf of the State. The Prime may suggest a particular financial institution that provides the necessary services for any account, but the State retains final	The Prime will be solely responsible for any losses to the State (or federal government, when applicable) resulting from inadequate internal controls, errors committed by its employee(s) or subcontractor(s), or misappropriation of funds by its employee(s) and/or subcontractor(s). Losses may include, but are not limited to: loss of funds (both State

Banking and Finance Operations		
#	**Performance Requirement**	**Damages**
	approval of any account where the State funds will be managed. Every account must be accessible in such a manner that all necessary transactions necessary to meet all related requirements of the RFP can be performed timely. The Prime must describe and provide to the State its procedures related to the account(s) in detail. The Prime must contract with a financial institution which has a presence in the State of Delaware and must be subject to the laws of the State of Delaware. The Prime may suggest arrangements such as unexpended funds being reinvested, for the State's consideration and approval. Fees charged by the selected bank will be passed through to the State except as otherwise noted in this RFP such as fees charged due to an error caused by the Prime. The State must be advised of fee changes with sufficient notice to be able to modify its accounts, if warranted. The Prime is responsible for ensuring that appropriate internal controls and segregation of duties, in accordance with Generally Accepted Accounting Principles (GAAP), are established, maintained, enforced and that the Prime remains strict compliance in all aspects of banking services at all times. The Prime is also responsible for establishing, maintaining, and enforcing appropriate and sufficient internal controls, especially to assure error avoidance and prevention of misappropriation of funds.	and federal); lost interest; bank fees; or other administrative costs or penalties which are incurred or determined by the State and/or federal government as a result of the Prime's failure to comply with the requirement(s).
2.	Bank Reconciliation The Contractor must reconcile bank statements for all financial bank accounts tracked via the Solution or ancillary system on a monthly basis or other schedule requested by DHSS. The bank accounts must balance. Within 30 calendar days from the date the Contractor received an account statement from the financial institution, the Contractor shall provide DHSS with a copy of the statement accompanied by a completed reconciliation.	The damages for failure to meet the standard will equal liquidated damages of $10,000 per month for each month that an account is not in compliance.
3.	Manual Check Reconciliation and Supporting Documentation For each manual check issued, the following documentation is required on file: Correspondence requesting issuance Supervisory approval Documentation verifying stop payment or voided check The Contractor will develop a database/spreadsheet reconciliation procedure to ensure duplicate manual checks are not issued as replacement for the same check/purpose, etc. The ability to sort this database various ways will allow reviewers to determine matching data on separate entries and find errors. The Contractor is responsible and accountable for all manual checks issued. A copy of the database, both printed and electronic, will be provided to the State on a periodic basis (weekly or monthly) for audit/review.	The damages for failure to meet any part of the standard will equal $1,000 per business day for each occurrence and for each performance measure not met.

Banking and Finance Operations		
#	**Performance Requirement**	**Damages**
4.	Banking Operating Procedures The Contractor will develop and update (no less than every six months) banking and finance desk level operating procedures that provide for all appropriate internal controls and segregation of duties. These procedures will require State review and approval.	The damages for failure to meet the standard will equal $1,000 per calendar day that desk level operating procedures are not available for DHSS review or do not reflect the proper updates.
5.	Check Printing and Backup Capability The Contractor shall print checks within four hours of the State's approval and shall have emergency procedures established to print checks within four hours, on another printer, should the primary check printer become non-functional.	The damages for failure to meet the printing standard will equal $1,000 per calendar day a backup printer is not available to print checks.
6.	System Generated Check In addition to other security measures required in the protection of blank and printed checks discussed herein, the Contractor will develop and maintain appropriate records regarding the transfer of printed checks from the printing facility to the mailroom. The number of checks transferred from the printing facility must match the number of checks delivered to the mailroom. The Contractor must confirm that the number of checks processed through the postage machine agrees with the number of checks delivered. Auditable records are required and the process must be described in the banking desk level operating procedures.	The damages for failure to meet the standard will equal $1,000 per calendar day auditable records are not available for DHSS review.
7.	Timeliness of Warrant File The Contractor shall email the Controller's Office by no later than 7:00 a.m., ET, following DHSS authorization, or according to any revised weekly schedules established by DHSS.	The damages for failure to meet this are up to $1,000 per hour for each hour (or fraction thereof) the warrant file is transmitted late, up to four hours. The damages for failure to meet this are $10,000 for each transmission later than four hours and for any transmission that cannot be processed due to the quality of the warrant file transmitted.
8.	MMIS Financial Entry All activity related to the issuance of drafts, from the Medicaid Disbursement Account, including, but not limited to system generated payments, manual issuance of special payments approved by DHSS, stale-dated checks, checks returned by the Post Office as undeliverable as addressed, and returned checks, must be posted to the MMIS, unless otherwise approved by the DHSS. All stale dated, undeliverable, stop payments, and returned checks must be posted	The damages for failure to meet any part of the standard will equal $1,000 per business day for each occurrence and for each performance measure not met.

Banking and Finance Operations		
#	Performance Requirement	Damages
	to the MMIS within 30 calendar days of the completion of the reconciliation of the current month's bank statement. All system-generated payments must be posted to the MMIS in conjunction with the completion of the weekly payment cycle. All manual issuance of special payments must be posted to the MMIS within 14 calendar days of the issuance of the payment.	
9.	Disbursing Account Interest The State will establish and maintain a claims draft account for use in making payments of benefits under the Medicaid program. This account will be in the name of and for the benefit of the State and will be used by the Contractor only for making authorized claims payments or Medicare Part A, Part B, and Part D premium payments. All funds in the account ("the float") shall be deposited in the State Treasury. The selected bank will be responsible for coordinating, on a daily basis, funding of the disbursement account with the State Treasurer. The Contractor shall withdraw, disburse, or use funds from the disbursement account solely for the purpose of paying claims and Medicare Part A, Part B, and Part D premiums under the Contract and shall be unequivocally and specifically prohibited from withdrawing, disbursing, or using funds from said account for any other purpose whatsoever, except upon the explicit, written instructions from the DHSS.	The damages for failure to meet the standard will equal liquidated damages of $10,000 for each occurrence that use of the account by the Contractor is not in compliance.

L.7.2.22 Failure to Notice Performance Requirements

Failure to Notice		
#	Performance Requirement	Damages
1.	The Contractor must notify DHSS in writing immediately upon discovery of any overpayments, duplicate payments, or incorrect payments regardless of cause. The Contractor must provide written explanation, cause, resolution, and timeframe for correction of the error per DHSS requirements.	The damages for failure to meet any part of the standard will equal liquidated damages of $1,000 per calendar day of delay the Contractor does not notify DHSS of erroneous payments.

L.7.2.23 EDP Audit Performance Requirements

Electronic Data Processing (EDP) Audit		
#	Performance Requirement	Damages
1.	The Contractor must complete and deliver a report on Controls Placed in Operation and Tests of Operating Effectiveness audit performed under Statement on Standards for Attestation Engagements (SSAE) No. 16, and International Standards on Assurance Engagements Report on Controls at a Service Organization (ISAE) 3402 Reporting on Controls at a Service Organization to DHSS by June 30 of each year. DHSS will specify the audit reports and level of detail required. Reporting is to begin upon Solution implementation.	The damages for failure to meet the June 30 date standard will equal $500 per calendar day or part thereof beyond June 30 of each year the audit is not completed to DHSS satisfaction
2.	The Contractor must respond with a proposed corrective action plan to the SSAE audits within 30 calendar days of receiving the audit report, if necessary. The Contractor must complete implementation of the State-approved corrective action plan within 40 calendar days of approval unless otherwise specified by the state. DHSS must approve the coverage period and auditor selected for the audit.	The damages for failure to meet the standard for submitting a corrective action plan will equal $500 per calendar day or any part thereof beyond the 30 calendar day requirement for submitting a corrective action plan that is satisfactory to DHSS. The damages for failure to meet the standard for implementing the corrective action plan will equal $500 per calendar day or any part thereof beyond the 40 calendar day requirement for implementing the corrective action plan.
3.	The Contractor must perform a biennial ADP risk analysis to ensure that appropriate, cost effective safeguards are incorporated into existing systems. A Report detailing the review will be provided to DHSS within 30 days of each review. In addition to these periodic reporting, the contractor must perform risk analyses and report results whenever significant system changes occur.	The damages for failure to perform and report on the risk analysis will equal $500 per calendar day that the report is overdue.

L.7.2.24 CMS Sanctions Performance Requirements

CMS Sanctions		
#	Performance Requirement	Damages
1.	Medicaid Manual, Part 11 The Contractor must perform all of its functions according to the terms required by the State Medicaid Manual, Part 11.	Consequential Damages If at any time during the life of the Contract CMS imposes fiscal sanctions against DHSS as a result of the Contractor's or any subcontractor's action or inaction, the Contractor shall compensate DHSS the amount of the sanctions.

L.7.2.25 System Documentation Performance Requirements

System Documentation		
#	Performance Requirement	Damages
1.	The Contractor is responsible for providing complete, accurate, and timely documentation for the Solution, per DHSS specifications. All documentation must be provided to DHSS in final form 30 calendar days prior to start date of operations for all Solution functions and be approved by DHSS.	The damages for failure to meet the standard are $200 for each State of Delaware business day, or any part thereof, from the date documentation was due until approved and accepted by DHSS.

L.7.2.26 Project Deliverables Performance Requirements

Project Deliverables		
#	Performance Requirement	Damages
1.	Project Deliverables Copies of each deliverable, as defined in the approved work plan must be delivered to DHSS in	The liquidated damages will be $1,000 per business day for each day the

Project Deliverables		
#	Performance Requirement	Damages
	final form, in the number specified, and on the date specified in the work plan. DHSS requires an electronic copy of all deliverables. The electronic copy must be compatible with Microsoft (MS) Word or other application software as requested by DHSS. All deliverables must be in a format approved by DHSS and meet content requirements specified or as subsequently defined by DHSS.	deliverable is late or unacceptable.
2.	Unless otherwise specified, milestones and phases that occur during all contract Phases must be completed by the Contractor, in final form, on the dates specified in the Contractor's work plan, as outlined in this RFP. DHSS must review and provide written acceptance of all milestones or phases.	The liquidated damages will be $1,000 per business day for each day the milestone or phase is late or unacceptable.

L.7.2.27 Key Dates Performance Requirements

Key Dates		
#	Performance Requirement	Damages
1.	The Contractor is required to complete the Implementation of the Delaware Medicaid Enterprise System by July 1, 2016. Other deliverable key dates will be defined in the approved work plan for the deliverables listed in Section 6.1.5 Anticipated Schedule. If, for any reason, the Contractor is delayed in meeting these key dates and a Contract modification to the work plan is not approved, damages may be assessed. Approval of a Contract or work plan modification does not waive DHSS's ability to impose damages if warranted by other sections of the Contract.	Up to $750 damages per State of Delaware business day, or any part thereof, may be assessed for each of the first 10 calendar days of delay in meeting a key date. Up to $1,500 damages per State of Delaware business day, or any part thereof, may be assessed for each of the 30 calendar days of delay, up to $2,500 damages per business day, or any part thereof, for each additional day of delay. DHSS retains the right to access actual damages for failure to meet key dates. The aforementioned damages in this

Key Dates		
#	Performance Requirement	Damages
		subsection shall be in addition to any amounts assessed for delays in meeting the operational start date. Ten thousand dollars ($10,000) may be assessed for the first month of each failure to meet any of the above requirements. Twenty thousand dollars ($20,000) may be assessed for each consecutive subsequent month a requirement remains unmet.

L.7.2.28 Minimum Cycles/File Update Processing Performance Requirements

Minimum Cycles/File Update Processing		
#	Performance Requirement	Damages
1.	The Contractor shall provide the following minimum number of file update and claims processing cycles under this Contract: Three edit/audit cycles per day. Three pricing cycles per day. One payment cycle per week. All external file updates applied within a week of receipt. These requirements will also be reviewed for the quality of the data input and data entry keying accuracy standards of 98%, as determined by DHSS reviews.	Up to $250 per hour damages may be assessed for each hour of delay in completing the file update process. Damages will not be assessed if the delay was caused by late receipt of files from DHSS. Up to $5,000 per incident may be claimed as damages for any weekly payment cycle or daily adjudication cycle that is not completed by 7:00 a.m. ET of the next morning after its scheduled processing, unless prior written approval is authorized by DHSS. Damages will not be assessed if the delay was caused by late receipt of files from DHSS.

L.7.2.29 Other Contract Provisions Performance Requirements

Compliance with Other Material Contract Provisions		
#	**Performance Requirement**	**Damages**
1.	The objective of this standard is to provide DHSS with an administrative procedure to address general Contract compliance issues that are not specifically defined as performance requirements listed above, but are Contractor responsibilities contained in Section 4 Vendor Responsibilities/Project Requirements. DHSS staff may identify Contract compliance issues resulting from deficiencies in the Contractor's performance through routine Contract monitoring activities. If this occurs, DHSS will notify the Contractor in writing of the nature of the performance issue. DHSS will also designate a period of time in which the Contractor must provide a written response to the notification and will recommend, when appropriate, a reasonable period of time in which the Contractor should remedy the non-compliance.	If the non-compliance is not corrected by the specified date, DHSS may assess liquidated damages up to the amount of $2,000 per State of Delaware business day after the due date until the non-compliance is corrected.
2.	The Contractor will submit Corrective Action Plan for DHSS approval to address failures. The Contractor will have 10 business days to submit to DHSS a corrective action plan to address the failure.	If Corrective Action Plan is not delivered by the specified date, DHSS may assess liquidated damages up to the amount of $2,000 per State of Delaware business day after the due date until it is delivered.
3.	Should the same error or performance failure reoccur the Contractor will be assessed liquidated damages	Additional liquidated damages of $1,000 will be assessed for each week or part of a week in which the failure occurs up to a maximum of $52,000 per year per occurrence.

L.7.2.30 Medicare Premium Payments Performance Requirements

Medicare Premium Payments		
#	Performance Requirement	Damages
1.	The State's Medicare premium liability must be paid to CMS in accordance with U.S. Department of Health and Human Services State Buy-In Manual, publication 100-15. The Contractor must ensure all eligible client premiums are paid and any discrepancies with CMS are resolved on a schedule defined by DHSS.	The damages for failure to meet the standard will equal actual damages equal to the charges assessed by CMS in accordance with the U.S. Department of Health and Human Services State Buy-In Manual, Pub.100-15 contained in the Medicaid Procurement Library paid by the Contractor.

L.7.2.31 Pharmacy Drug Rebate Performance Requirements

Pharmacy Drug Rebate		
#	Performance Requirement	Damages
1.	Resolve federal, State, and supplemental rebate disputes and past due balances and not let the combined amount exceed 200.	The damages for failure to meet the standard will equal a 2.5% reduction in the Contractor's monthly invoice

L.7.2.32 Unexpected Costs Performance Requirements

Unexpected Costs		
#	Performance Requirement	Damages
1.	The Contractor shall be responsible for payment or re-payment to the State of Delaware for any unexpected or unforeseen situation that creates monetary costs for the State.	Failure to adequately compensate or reimburse the State of Delaware for any such losses will result in damages assessed at $2,000 per day plus the interest on any unpaid sum owed to the State.

M ATTACHMENT M: HIPAA COMPLIANCE MATRIX

HIPAA Compliance Matrix

Compliance Requirements	Source	Bidder Meets Requirement Y/N	How Bidder Meets or Intends to Meet the Requirement
TRANSACTION STANDARDS AND CODE SETS:			
Health Care Claims/Encounters:	45 CFR 162, I00		EDI = Electronic Data Interchange, IVR = Interactive Voice Response, NDM = National Data Mover
ASC X 12N 837 Health Care Claim/Encounter: Professional, Version 4010A			**EDI** ☐ **IVR** ☐ **NDM** ☐ **Web Portal** ☐ **Clearinghouse** ☐ **Other** ☐
ASC X 12N 837 Health Care Claim/Encounter: Institutional, Version 4010A			**EDI** ☐ **IVR** ☐ **NDM** ☐ **Web Portal** ☐ **Clearinghouse** ☐ **Other** ☐
ASC X 12N 837 Health Care Claim/Encounter: Dental, Version 4010A			**EDI** ☐ **IVR** ☐ **NDM** ☐ **Web Portal** ☐ **Clearinghouse** ☐ **Other** ☐
National Council for Prescription Drug Programs (NCPDP) Version 5.1 and equivalent NCPDP Batch Standard Version 1 Release 2			**EDI** ☐ **IVR** ☐ **NDM** ☐ **Web Portal** ☐ **Clearinghouse** ☐ **Other** ☐
Eligibility for a Health Plan:	45 CFR 162, I00		
ASC X 12N 270/271 Health Care Eligibility Benefit Inquiry and Response, Version 4010A			**EDI** ☐ **IVR** ☐ **NDM** ☐ **Web Portal** ☐ **Clearinghouse** ☐ **Other** ☐
Referral Certification and Authorization:	45 CFR 162, I00		

Compliance Requirements	Source	Bidder Meets Requirement Y/N	How Bidder Meets or Intends to Meet the Requirement
ASC X 12N 278 Health Care Services Review Request for Review and Response, Version 4010A			EDI ☐ IVR ☐ NDM ☐ Web Portal ☐ Clearinghouse ☐ Other ☐ Other: _____
Health Care Claim Status:	45 CFR 162, I00		
ASC X 12N 276/277 Health Care Claim Status Request and Response, Version 4010A			EDI ☐ IVR ☐ NDM ☐ Web Portal ☐ Clearinghouse ☐ Other ☐ Other: _____
Enrollment and Disenrollment:	45 CFR 162, I00		
ASC X 12N 834 Benefit Enrollment and Maintenance, Version 4010A			EDI ☐ IVR ☐ NDM ☐ Web Portal ☐ Clearinghouse ☐ Other ☐ Other: _____
Health Care Payment and Remittance Advice:	45 CFR 162, I00		
ASC X 12N 835 Health Care Claim Payment/Advice, Version 4010A			EDI ☐ IVR ☐ NDM ☐ Web Portal ☐ Clearinghouse ☐ Other ☐ Other: _____

Compliance Requirements	Source	Bidder Meets Requirement Y/N	How Bidder Meets or Intends to Meet the Requirement
Health Plan Premium Payments:	45 CFR 162, I00		
ASC X 12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products, Version 4010A			**EDI** ☐ **IVR** ☐ **NDM** ☐ **Web Portal** ☐ **Clearinghouse** ☐ **Other** ☐ Other: _____
Coordination of Benefits:	45 CFR 162, I00		
ASC X 12N Health Care Claim: Professional, Version 4010A			**EDI** ☐ **IVR** ☐ **NDM** ☐ **Web Portal** ☐ **Clearinghouse** ☐ **Other** ☐ Other: _____
ASC X 12N 837 Health Care Claim: Institutional, Version 4010A			**EDI** ☐ **IVR** ☐ **NDM** ☐ **Web Portal** ☐ **Clearinghouse** ☐ **Other** ☐ Other: _____
ASC X 12N 837 Health Care Claim: Dental, Version 4010A			**EDI** ☐ **IVR** ☐ **NDM** ☐ **Web Portal** ☐ **Clearinghouse** ☐ **Other** ☐ Other: _____
NCPDP Version 5, Release 1, and equivalent NCPDP Batch Standard Version 1, Release 2			**EDI** ☐ **IVR** ☐ **NDM** ☐ **Web Portal** ☐ **Clearinghouse** ☐ **Other** ☐ Other: _____

Compliance Requirements	Source	Bidder Meets Requirement Y/N	How Bidder Meets or Intends to Meet the Requirement
Acknowledgement:	45 CFR 162, I00		
ASC X 12N 997: Functional Acknowledgement			**EDI** ☐ **IVR** ☐ **NDM** ☐ **Web Portal** ☐ **Clearinghouse** ☐ **Other** ☐ Other: _____
ASC X 12NTA1: Interchange Acknowledgement			**EDI** ☐ **IVR** ☐ **NDM** ☐ **Web Portal** ☐ **Clearinghouse** ☐ **Other** ☐ Other: _____
HIPAA Required Code Sets	45 CFR 162, J		
ABA Routing Number	Thomson Financial Publishing		
Countries - ISO 3166	American National Standards Institute (ANSI) - ISO 3166		
Countries - ISO 3166	ISO 3166 Maintenance Agency		
Currencies and Funds - ISO 4217	ANSI ISO 4217		
Currencies and Funds - ISO 4217	BSI Currency Code Service		
D-U-N-S Number	Dun & Bradstreet		
States and Outlying Areas of the U.S.	U.S. Postal Service		
Universal Product Code	Uniform Code Council, Inc.		
FIPS-55	U.S. Geological Survey		

Compliance Requirements	Source	Bidder Meets Requirement Y/N	How Bidder Meets or Intends to Meet the Requirement
ZIP Code	U.S. Postal Service		
DFI Identification Number	Thomson Financial Publishing		
X12.3 Data Element Dictionary/X12.22 Segment Directory	Data Interchange Standards Association, Inc. (DISA)		
International Organization for Standardization (Date and Time)	ANSI - ISO 8601		
Languages	ANSI - ISO 639		
Health Industry Identification Number	Health Industry Business Communications Council		
Healthcare Common Procedure Coding System (HCPCS)	Centers for Medicare & Medicaid Services (CMS)		
International Classification of Diseases and Related Health Problems, Tenth Revision, Clinical Modification (ICD-10-CM) ICD-10-PCS (Procedure Coding System)	U.S. National Center for Health Statistics		
National Uniform Billing Committee (NUBC) Codes	National Uniform Billing Committee		
Current Procedural Terminology (CPT) Codes	Order Department (AMA)		
National Drug Code	U.S. Food and Drug Administration (FDA)		
American Dental Association Codes (CDT-4)	American Dental Association		

Compliance Requirements	Source	Bidder Meets Requirement Y/N	How Bidder Meets or Intends to Meet the Requirement
Claim Adjustment Reason Codes	Washington Publishing Company		
Health Care Financing Administration (HCFA) - Code Lists	CMS		
Diagnosis Related Group Number (DRG)	Superintendent of Documents – U.S. Government Printing Office		
Admission Source Code	National Uniform Billing Committee		
Admission Type Code	National Uniform Billing Committee		
Claim Frequency code	National Uniform Billing Committee		
Uniform Billing Claim Form Bill Type	National Uniform Billing Committee		
Place of Service	CMS		
Patient Status Code	National Uniform Billing Committee		
National Drug Code by Format	Federal Drug Listing Branch HFN-315		
National Association of Insurance Commissioners (NAIC) Code	NAIC		
National Association of Boards of Pharmacy Number	National Council for Prescription Drug Programs		
Treatment Codes	CMS		
Remittance Remark Codes	Washington Publishing Company		
National Information Standards Organization (NISO) Z39.53 Language Code List	NISO Press		

Compliance Requirements	Source	Bidder Meets Requirement Y/N	How Bidder Meets or Intends to Meet the Requirement
Health Care Claim Status Category Code	Washington Publishing Company		
Health Care Claim Status Code	Washington Publishing Company		
Home Infusion Electronic Data Interchange (EDI) Coalition (HIEC) Code List	HIEC		
NCPDP Reject/Payment Codes	NCPDP		
Health Care Financing Administration National Provider Identifier (NPI)	CMS		
HCFA National Plan ID	CMS		
HCFA Public Use Files	CMS		
Canadian Province Abbreviations	Canadian Postal Service		
Clinical Laboratory Improvement Amendments (CLIA) Number	CMS		
National Uniform Billing Committee (NUBC) Condition Codes	NUBC		
NUBC Occurrence Codes	NUBC		
NUBC Occurrence Span Codes	NUBC		
NUBC Value Codes	NUBC		
UB92 Bill Type Code	NUBC		
UB92 Facility Type Code (2 digits)	NUBC		
UB92 Revenue Codes	NUBC		
Indian Health Service (IHS)/Contract Health Services (CHS) Tribal Residency Codes	IHS		
Provider Taxonomy Codes	Washington Publishing Company		

Compliance Requirements	Source	Bidder Meets Requirement Y/N	How Bidder Meets or Intends to Meet the Requirement
CMS Carrier Numbers	CMS		
Listing of Home Health Resource Groups (HHRGs), Health Insurance Prospective Payment System (HIPPS) Codes and Weights	CMS		
Health Industry Labeler Identification Code	Health Industry Business Communications Council (HIBCC)		
Dept. of Defense DOD1 - Military Rank and Health Care Services Region	TRICARE		
EDI Formats	Washington Publishing Company		
Social Security Number	Social Security Administration		
PRIVACY STANDARDS			
Use and Disclosure of Protected Health Information (PHI)			
Authorization Requirements – Forms and Procedures	45 CFR 164.508		
Permitted Uses and Disclosures	45 CFR 164.502 (a)		
Minimum Necessary Policy and Procedures	45 CFR 164.502(b)		
Uses and Disclosures Permitted without Consent	45 CFR 164.512		
Public Health Activities	45 CFR 164.512(b)		
Victims of Abuse, Neglect, Violence	45 CFR 164.512		
Additional Use and Disclosure Rules	45 CFR 501(4)		

Compliance Requirements	Source	Bidder Meets Requirement Y/N	How Bidder Meets or Intends to Meet the Requirement
Patient Rights			
Right to Notice of Privacy Practices – including Notice form and procedures	45 CFR 164.520		
Right to Request Restriction of Uses & Disclosures	42 CFR 164.522		
Right of Access to Protected Health Information (PHI)	42 CFR 164.524		
Right to Request Amendment of PHI	42 CFR 164.526		
Right to Accounting of Disclosures of PHI – including Record of Disclosures Policy and Procedure	42 CFR 164.528		
Administrative Requirements			
Designation of Privacy Official – Identify Individual	45 CFR 164.530(a)		
Complaint Procedures	45 CFR 164.530 (d)		
Privacy Training (Timing, Documentation)	45 CFR 164.530(b)		
Sanctions for Non-Compliance	45 CFR 164.530 (e)		
Mitigation Policy, Procedure and Practices	45 CFR 164.530 (f)		
Administrative Safeguards-Policy and Procedure	45 CFR 164.530 (c)		
Documentation of Policies and Procedures	45 CFR 164.530 (j)		
Business Associate Agreement	164.314 (a)		
	164.314(a)(2)(i)		

Compliance Requirements	Source	Bidder Meets Requirement Y/N	How Bidder Meets or Intends to Meet the Requirement
SECURITY STANDARDS			
Administrative Procedures	45 CFR 142.308		
Contingency Plan (Electronic & Non-Electronic Data)			
Trading Partner Agreements			
Information Access Controls			
Internal Audit			
Personnel Security			
Security Incident Procedures – including Notice of Breach to Individuals and Mitigation			
Security Management Process			
Termination Procedures			
Security Awareness Training			
Security Incidents – Record of Breaches and Responses			
Physical Safeguards			
Assigned Security Responsibility – Identify Security Official			
Media Access Controls			
Physical Access Controls			
Work Station Use Policies and Procedures			
Technical Security Safeguards			
Monitoring and Testing			
Communication/Network Integrity Controls			
Security Configuration Management			

Compliance Requirements	Source	Bidder Meets Requirement Y/N	How Bidder Meets or Intends to Meet the Requirement
Message Authentication			
Access Controls or Encryption			
Audit Trail			
Entity Authentication			
Event Reporting			
Security Training			
Email Privacy & Security			
Archiving Policies and Practices			
Conditions for the Use of PHI in Email			
Encryption			
Patient Identification			
Address Management			
Inclusion in Medical Record			
Software Contractor HIPAA Readiness			
UNIQUE HEALTH CARE IDENTIFIERS			
Providers – NPI Compliance Deadline May 23, 2007			
Employers			
Individuals			
Health Plans			
RESEARCH			
Use and Disclosure for Research			
Institution Review Board (IRB) Approval	45 CFR 164.512 (I)		
Individual Authorization	45 CFR 164.512 (I)		

N ATTACHMENT N: PERSONNEL – MINIMUM QUALIFICATIONS, ROLES, AND RESPONSIBILITIES

Named staff persons must be employed by, or committed to join, the Contractor's or the committed Subcontractor's organization by the beginning of the pertinent contract phase or task.

The term "special consideration" in this section means that proposed individuals who have the additional related qualifications listed will be given a higher overall rating in the evaluation process than those candidates who do not have them.

Named Staff Positions

The Contractor must include names and resumes for identified high-level positions, assure that named staff meets the qualification requirements, and assure that named staff will be devoted to the Contract as bid subject to Actual and Liquidated Damages Attachment L – Contract Terms and Conditions, Section 7.2.9. Positions that are designated as "named staff" shall not remain vacant for more than 30 calendar days. Named staff positions shall not be occupied by employees who will fulfill the roles and responsibilities of the position in a temporary capacity and/or maintain responsibilities for another position. Any proposed change to named staff after Contract execution must have prior written approval by DHSS.

For each Named Staff position, the Contractor must describe its plan and commitment for staffing each phase of the Contract. Each proposed Named Staff member must have extensive MMIS application knowledge and technical expertise necessary to perform or administer the roles and responsibilities correlating to each Named Staff position.

The following table provides named staff positions, minimum qualifications for each, and corresponding roles and responsibilities for the project. Other positions may be proposed at the Contractor's discretion.

Table N-1: Named Staff Qualifications

Named Staff Position	Qualifications	Roles and Responsibilities	Tasks: PM = Project Management Oversight DDI = Design Development, Implementation O&M = Operations and Maintenance Systems Support OPS = Operations All = All Tasks
Project Director (PD)	Minimum of 5 years of direct project oversight and authority over projects in excess of $40 million. Special consideration will be given to those who have previously managed MMIS accounts that have included both development and systems operations and operations and maintenance phases, and have experience working with HIPAA Privacy and Security Rules.	The Project Director will be the responsible party if issues arise that cannot be resolved with the Contractor's Project Manager. The PD will be the primary point of contact with the State's Contract Administrator and Executive Sponsors for activities related to contract administration, overall project management and scheduling, correspondence between the State and Contractor, dispute resolution, and status reporting to the State for the duration of the contract. The PD does not need to be onsite except for designated meetings or as requested. It is critical that a named PD with appropriate experience be proposed.	All **Start Date:** After contract signing.

Named Staff Position	Qualifications	Roles and Responsibilities	Tasks: PM = Project Management Oversight DDI = Design Development, Implementation O&M = Operations and Maintenance Systems Support OPS = Operations All = All Tasks
Project Manager (PM)	Minimum of 5 years of account management experience for a government or private sector health care payer, including a minimum of 3 years of Medicaid systems experience in a state similar in scope and size to Delaware. A bachelor's degree in business management or a related field is also required. Special consideration will be given to those who possess a project management certification equivalent to the Project Management Institute's (PMI) Project Management Professional (PMP) certification.	The Project Manager provides onsite management of the project from the Contractor perspective and is the chief liaison for the State PD and State staff for design, development, and implementation (DDI) project activities. The PM is authorized to make day-to-day project decisions that do not necessarily affect the overall scope and schedule of the project. The PM is responsible for facilitating the project by using the project management processes, organizing the project, and managing the team work activities consistent with the approved work plan. The PM is responsible for scheduling and reporting project activities, coordinating use of personnel resources, identifying issues and solving problems, overseeing disaster recovery, and facilitating implementation of the system. The PM shall not serve in any other named staff position during the DDI phase of the project. The PM is expected to host weekly/weekly onsite status meetings, monthly milestone meetings, as well as interim meetings. The PM will assign Contractor staff to those meetings as appropriate. The PM will provide an agenda and develop minutes for each meeting.	All **Start Date:** After contract signing

Named Staff Position	Qualifications	Roles and Responsibilities	Tasks: PM = Project Management Oversight DDI = Design Development, Implementation O&M = Operations and Maintenance Systems Support OPS = Operations All = All Tasks
Deputy Project Manager (Deputy PM)	Minimum of 4 years of account management experience for a government or private sector health care payor, including a minimum of 2 years of Medicaid systems experience. A bachelor's degree is required. Special consideration will be given to those who possess a project management certification equivalent to the Project Management Institute's (PMI) Project Management Professional (PMP) certification.	The Deputy Project Manager is part of the Contractor's onsite management team and is the secondary point of contact with the State staff for project activities. Responsible for facilitating the project by using the project management processes, organizing the project, and managing the team work activities consistent with the approved work plan. The Deputy PM, assigned at the PM's discretion, is responsible for scheduling and reporting project activities, coordinating use of personnel resources, and facilitating implementation of the system. The Deputy PM shall not serve in any other key person role during the DDI phase of the project. The Deputy PM is expected to be involved in all aspects of the project and attend/host meetings with DHSS as necessary. and act on behalf of the project in the absence of the PM.	All **Start Date:** After contract signing OPS Moves to Deputy Account Manager during the OPS project phase.
Configuration Manager	Two years of configuration management experience for a large systems development project. Special consideration will be given to those who have previously provided configuration management on other MMIS projects.	The Configuration Manager manages the Contractor's development activities related to software version control during the life of the project, including version control for new development, modification, reuse, reengineering, maintenance, and all other activities resulting in software products. Utilizes tools for monitoring, and provides insight	PM **Start Date:** After contract signing. Ends at the completion of the implementation task.

Named Staff Position	Qualifications	Roles and Responsibilities	Tasks: PM = Project Management Oversight DDI = Design Development, Implementation O&M = Operations and Maintenance Systems Support OPS = Operations All = All Tasks
		into the processes to be followed, the methods to be used, and the approach for version control activities.	
Quality Control Manager	Three years of experience in quality control and oversight, including one year of experience as a Quality Control Manager. Special consideration will be given to those who have previously provided quality control expertise on other MMIS projects and those with quality-related certifications.	The Quality Control Manager provides overall quality oversight for the Contractor's work products. Coordinates quality activities and reviews such as risk analysis and issue management with the project's Quality Control Contractor and DHSS's Project Managers, to ensure consistency of project management and to standardize project operations.	PM **Start Date:** After contract signing. Ends at the completion of the implementation task.
Core Medicaid Enterprise Systems Implementation Manager	Minimum of 5 years of Medicaid-related system management experience, including the management of at least 1 MMIS project. Special consideration will be given to those who possess a bachelor's degree in Information Systems Management or System Architecture Engineering	The Core Medicaid Enterprise Systems Manager is responsible for managing the design, development, and testing activities of individual Medicaid Enterprise System core components and interfaces. Provides oversight to ensure systems properly execute business rules and meets requirements; State and Contractor staff are familiar with system issues and work together to resolve during configuration, testing, and implementation; and the individual system components and the overall DMES meet operational readiness requirements.	DDI **Start Date:** After contract signing. Ends at the completion of the implementation task.

Named Staff Position	Qualifications	Roles and Responsibilities	Tasks: PM = Project Management Oversight DDI = Design Development, Implementation O&M = Operations and Maintenance Systems Support OPS = Operations All = All Tasks
Systems Implementation Manager	Four years of experience in systems implementation for large system development projects. Special consideration will be given to those who have previously implemented MMIS projects.	The Systems Implementation Manager is responsible for developing and updating the Implementation Plan. Ensures the production environment is properly established, including software installation, site preparation, and installation schedule. Oversees final data and file conversion activities and final system interface tests. Ensures delivery of final system documentation. Monitors system processing to ensure that all functions and features are operating correctly, and manages correction of errors identified during the initial operations period. Ensures the optimal processing of the new DMES, including production monitoring, emergency maintenance, and data resource management activities.	DDI.
Data Conversion Manager	Minimum of 3 years of experience in leading the conversion of large-scale health data, with at least 1 year in Medicaid and with at least 1 year in a management capacity. Special consideration will be given to those who have previously provided data conversion expertise on MMIS implementations.	The Data Conversion Manager is responsible for identifying data to be converted and mapping data between current systems and the future system. Manages testing of conversion programs. Oversees the conversion activities including identifying, tracking and resolving data anomalies; managing conversion design; assuring issues are presented and addressed; and assuring data is cleansed, loaded, and balanced in the system to meet State requirements.	DDI

Named Staff Position	Qualifications	Roles and Responsibilities	Tasks: PM = Project Management Oversight DDI = Design Development, Implementation O&M = Operations and Maintenance Systems Support OPS = Operations All = All Tasks
System and Web Architect	Minimum of 5 years of experience as a system and web architect on large system development projects. Experience in the architecture and tools of the proposed system. Experience in managing development staff. Special consideration will be given to those who have previously implemented MMIS projects. Latest Start Date: Immediately following contract execution.	The System and Web Architect is responsible for the overall engineering and development of the DMES application. Directs and coordinates all levels of the data and process modeling, work process, user interface design, technological infrastructure design (network, distribution, security, etc). Responsible for the system development process and the development of appropriate work activities, tasks, and estimates. Mentors and supports the project staff in their various roles and responsibilities.	DDI **Start Date:** After contract signing. Ends at the completion of the implementation task.
Systems Integration Manager	Minimum of 3 years of systems integration experience for a government or private sector health care payer, Special consideration will be given to those who possess a bachelor's degree in Information Systems Management, System Architecture Engineering, or similar specialty and have at least 3 years of MMIS implementation and integration experience.	The Systems Integration Manager provides oversight in the development of the Interface Specification Design Document and Interface Control documents. Manages the development of the service-oriented architecture (SOA) framework, the Enterprise Service Bus (ESB), Application Programming Interfaces (API), and system interfaces throughout the DMES in accordance with governance standards. Ensures appropriate integration of modules with workflow management and business rules engine. Maintains an inventory of DMES interfaces.	DDI O&M **Start Date:** After contract signing. Continues on to contract end date.
Testing Manager	Minimum of 4 years of experience as a testing professional working	The Testing Manager coordinates all project testing efforts. Participates in the	DDI

Named Staff Position	Qualifications	Roles and Responsibilities	Tasks: PM = Project Management Oversight DDI = Design Development, Implementation O&M = Operations and Maintenance Systems Support OPS = Operations All = All Tasks
	on large system development projects, including 1 year managing the testing effort. Special consideration will be given to those who have previously worked on MMIS implementations.	development of the Test Plan. Coordinates, plans, documents, and facilitates the testing preparation, activities, and tasks. Creates the test strategy and plans, oversees testing processes, test scripts, preparation of test environments, ensures that all requirements are tested, and reports defects and defect resolution.	
Database Administrator	Minimum of 3 years of experience as a Database Administrator using the database included in the base system and the database that will be implemented, if different from the base system database. Special consideration will be given to those who have previously provided database administration activities for large MMIS implementations.	The Database Administrator participates in the planning and managing of the various database environments, including development, testing, and production. Creates and maintains the computer database system. Ensures a working database environment. Facilitates the definition and implementation of the information requirements associated with the business processes. Models the information requirements for validation with the system stakeholders. Creates the physical database including scripts for ongoing support and maintenance. Resolves data access performance issues.	DDI
Systems Administrator	Minimum of 3 years of experience in systems administration for a large system development project. Special consideration will be given to those who have previously provided systems	The Systems Administrator is responsible for effective provisioning, installation, configuration, operation, and maintenance of systems hardware and software and related infrastructure. Performs daily system monitoring, verifying the integrity and availability of all	DDI O&M

Named Staff Position	Qualifications	Roles and Responsibilities	Tasks: PM = Project Management Oversight DDI = Design Development, Implementation O&M = Operations and Maintenance Systems Support OPS = Operations All = All Tasks
	administration expertise on MMIS implementations.	hardware, server resources, systems and key processes, reviewing system and application logs, and verifying completion of scheduled jobs such as backups. Perform regular security monitoring to identify any possible intrusions. Create, change, and delete user accounts as requested.	
Senior Systems Analyst (5) (Senior Programmer/ Analyst) for Claims, Provider, Recipient & Reporting – Client-Facing Resource	Minimum of 3 years of MMIS experience including 2 years with the proposed solutions. A bachelor's degree is required.	The Senior Systems Analyst represents expertise in specific DMES program areas and participates with the Contractor's and DHSS's project teams in collaborative development. Provides liaison between stakeholder groups and the project. Ensures the project staff clearly understands the specific business requirements, covering the breadth of DMES Functionality. Ensures the business requirements are incorporated into the application, and ensures the work processes are in alignment with the new application.	DDI **Start Date:** After contract signing. Ends at the completion of the implementation task except O&M A minimum of at least three (3) persons will continue through the O&M Task.
Fiscal Agent Account Manager	Minimum of 3 years of experience in contracts management and oversight of Fiscal Agent operations. Special consideration will be given to those who have previously managed MMIS accounts on large information system efforts that have	The Fiscal Agent Account Manager is the primary point of contact with the State's Contract Administrator and Executive Sponsors for activities related to contract administration, overall project management and scheduling, correspondence between the State and Contractor, dispute resolution, personnel issues with Contractor staff, and status reporting to the	OPS O&M

Named Staff Position	Qualifications	Roles and Responsibilities	Tasks: PM = Project Management Oversight DDI = Design Development, Implementation O&M = Operations and Maintenance Systems Support OPS = Operations All = All Tasks
	included both development and IT operations phases, participated in the DDI phase of this project, and/or have previously coordinated MMIS business improvement activities that have included both development and operations phases.	State. Also leads and coordinates the Contractor's implementation activities, including implementation evaluation, training, coaching, mentoring, reporting, and recommendation activities. The Fiscal Agent Account Manager shall not serve in any other key role for this phase of the project.	
Provider Services Manager	Minimum of 4 years of experience managing provider relations functions for a Medicaid Program, other government health care program, or health care-related organization. Experience and/or training in member eligibility management and significant experience in a call center operation are required. A bachelor's degree is required.	The Provider Services Manager plans, directs and manages: the enrollment maintenance and communication processes for providers and clients, interaction with all providers via the web, call center, Point of Sale (POS), Electronic Verification System (EVS), mailroom, and Electronic Health Record (EHR) incentive team.	OPS
Claims Operations Manager	Minimum of 4 years of experience managing claims processing operations and personnel for a government or private sector health care payor, including a minimum of 2 years of MMIS experience. A bachelor's degree is	The Claims Operations Manager is responsible for supervising and training staff and oversight of all the department's functions. Responsible for directing the planning, design, development, implementation, and evaluation of policies and procedures that assure accurate, timely claims and encounter processing. Ensures all information and	OPS

Named Staff Position	Qualifications	Roles and Responsibilities	Tasks: PM = Project Management Oversight DDI = Design Development, Implementation O&M = Operations and Maintenance Systems Support OPS = Operations All = All Tasks
	required.	documents required for claims and encounter processing and related inquiries to assure compliance with all applicable rules, regulations, and external and internal policies and procedures.	
Quality Assurance Manager	Certification from a quality assurance program and/or a minimum of 3 courses in college-level mathematics or statistics. A minimum of 3 years of progressive experience in the quality assurance function of a large-scale claims processing organization. A bachelor's degree is required.	The Quality Assurance Manager will use industry best practices and quality control principles to assure that state requirements are appropriately met and that quality is built into the system and all vendor processes.	OPS O&M
Systems Group Manager	Minimum of 4 years of experience in health care claims processing systems development, design, and programming in a large systems environment. Special consideration will be given to those who have PMP or other relevant professional certification and/or have participated in the DDI phase of this project.	The Systems Group Manager is the primary point of contact with the State staff for system maintenance and modification activities. The Systems Group Manager is responsible for scheduling and reporting maintenance and modification activities, coordinating use of modification task personnel resources, facilitating and scheduling the implementation of system modifications, and disaster recovery. The Systems Group Manager shall not serve in any other key role.	O&M

Named Staff Position	Qualifications	Roles and Responsibilities	Tasks: PM = Project Management Oversight DDI = Design Development, Implementation O&M = Operations and Maintenance Systems Support OPS = Operations All = All Tasks
Privacy / Security Specialist	Minimum of 3 years of professional IS auditing, control or security work experience with at least 1 year in a management capacity. Experience must also include at least 2 years working with HIPAA Privacy and Security Rules. Must be either Certified IS Auditor (CISA) or Certified IS Security Professional (CISSP). Special consideration will be given to those who have experience implementing or overseeing ISO 17799 security standards.	The Privacy/Security Specialist is the primary point of contact with the State staff for the development, implementation, and maintenance of the policies and procedures of a covered entity throughout HIPAA and all regulations issued hereunder and for compliance with the regulation, generally. The Privacy/Security Specialist is also the primary point of contact with DHSS staff for conducting, reviewing, and updating auditing procedures, policies, and log reviews.	DDI
Pharmacy Manager	Experience in managing pharmacy benefits management programs.	The Pharmacy Manager manages all pharmacy resources including all aspects of the pharmacy call center, Drug Rebate program, and Drug Utilization Review.	All

Categorized Staff Positions

Categorized staff includes those positions that the Contractor will be required to maintain in sufficient numbers to meet the specific service levels in Attachment L – Contract Terms and Conditions. Resume submission is not required for categorized staffing positions with this proposal. Staff occupying Categorized Staff positions must meet the qualifications listed in Table N-2: Categorized Staff Qualifications.

The following table provides Categorized Staff positions and minimum qualifications for each working on the project. The Categorized Staff positions play important roles on the project and require DHSS approval prior to starting on the project.

Other positions may be proposed at the Contractor's discretion.

Table N-2: Categorized Staff Qualifications

Categorized Staff Position	Qualifications/Requirements
Technical Lead	Minimum of 3 years of experience as a technical lead using software tools utilized in MMIS development. Experience with DDI and operations of an MMIS or similar health care system is strongly preferred. Special consideration will be given to those who participated in the DDI phase of this project.
Administrative Staff	Education or training relevant to the business function, with no additional specified education or experience requirement.
Internet/Intranet Programmer Analyst	Minimum programming degree or certification and 2 years Web-based programming experience.
Certification Manager	Minimum of 3 years of Medicaid-related system design and management experience including the management of one MMIS design and development project similar in size and scope to this project. A bachelor's degree is required. Special consideration will be given to those who have prior experience with the Centers for Medicare & Medicaid Services (CMS) Medicaid Enterprise Certification Toolkit (MECT) and successful certification of an MMIS.
Buy-in Coordinator	A bachelor's degree and at least 2 years of experience determining eligibility for Medicare savings programs or dual Medicare/Medicaid eligibility; a thorough knowledge of buy-in processing and the federal buy-in files and file structures.
Financial Analyst/Banking Manager	Minimum of 3 years of banking, accounting, or auditing experience. Degree in Finance or Accounting is required. Special consideration will be given to those who are actively licensed as a Certified Public Accountant (CPA) or Certified Internal Auditor (CIA).
Business Analyst (Analyst category)	Minimum professional degree or certification and 2 years of experience in the professional field.
Systems Analyst (Programmer category)	Minimum programming degree or certification and 2 years of programming experience.
Reference Business Analyst for ClaimCheck® product (Analyst category)	Business Analyst with thorough knowledge of ClaimCheck® or similar product proposed by the Contractor.
Pharmacists (Medical personnel category)	Registered Pharmacist with a current Delaware license.
Pharmacy Technician	Pharmacy Technician with a current Delaware license.
Customer Service Manager	Minimum of 2 years of experience in managing customer relations for a health care program or health care system.
Call Center Staff	Education or training related to the business function, with no additional specified education or experience requirement.
Help Desk Staff	Minimum professional degree or certification and 2 years of experience in the professional field.
Training Lead	Minimum 3 years of experience as a training professional on large system development projects, including 1 year managing the training effort. Special consideration will be given to those who have previously provided training lead expertise on MMIS implementations and have trained a wide variety of users.

Categorized Staff Position	Qualifications/Requirements
Trainer	Minimum professional degree or certification and 2 years of experience in the professional field.
Data Specialist	Minimum professional degree or certification and 2 years of experience in the professional field.
Turnover Project Manager	Minimum professional degree or certification and 2 years of experience in the professional field.

	PHASE							
Position	Project Management Oversight and Planning	Design	Development	Test	Implementation and Training	Certification	FA Operations and Systems O&M Support	Turnover
Project Director (PD)	↔	↔	↔	↔	↔	↔	↔	↔
Project Manager (PM)	↔	↔	↔	↔	↔	↔	↔	↔
Deputy Project Manager (Deputy PM)	↔	↔	↔	↔	↔	↔	↔	↔
Configuration Manager	↔	↔	↔	↔	↔	–	–	–
Quality Control Manager	↔	↔	↔	↔	↔	–	–	–
Implementation Manager (Core Medicaid Enterprise System)	↔	↔	↔	↔	↔	–	–	–
Systems Implementation Manager (DDI)	–	↔	↔	↔	↔	–	–	–
Data Conversion Manager	–	↔	↔	↔	↔	–	–	–
System and Web Architect	↔	↔	↔	↔	↔	–	–	–
Systems Integration Manager	–	↔	↔	↔	↔	↔	↔	↔
Testing Manager	–	↔	↔	↔	↔	–	–	–
Data Base Administrator	–	↔	↔	↔	↔	–	–	–
Systems Administrator	–	↔	↔	↔	↔	↔	↔	↔
Senior Systems Analsyt	↔	↔	↔	↔	↔	↔	↔	↔
Fiscal Agent Account Manager	–	–	–	–	–	↔	↔	↔
Povider Service Manager	–	–	–	–	–	↔	↔	↔
Claims Operation Manager	–	–	–	–	–	↔	↔	↔
Quality Assurance Manager	–	–	–	–	–	↔	↔	↔
Systems Group Manager	–	–	–	–	–	↔	↔	↔
Privacy Security Specialist	–	↔	↔	↔	↔	–	–	–
Pharmacy Account Manager	↔	↔	↔	↔	↔	↔	↔	↔

O ATTACHMENT O: CERTIFICATION AND STATEMENT OF COMPLIANCE

DELAWARE HEALTH AND SOCIAL SERVICES
REQUEST FOR PROPOSAL

CERTIFICATION SHEET

As the official representative for the Bidder, I certify on behalf of the agency that:

a. They are a regular dealer in the services being procured.

b. They have the ability to fulfill all requirements specified for development within this RFP.

c. They have independently determined their prices.

d. They are accurately representing their type of business and affiliations.

e. They will secure a Delaware Business License.

f. They have acknowledged that no contingency fees have been paid to obtain award of this contract.

g. The Prices in this offer have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other contractor or with any competitor;

h. Unless otherwise required by Law, the prices which have been quoted in this offer have not been knowingly disclosed by the contractor and prior to the award in the case of a negotiated procurement, directly or indirectly to any other contractor or to any competitor; and

i. No attempt has been made or will be made by the contractor in part to other persons or firm to submit or not to submit an offer for the purpose of restricting competition.

j. They have not employed or retained any company or person (other than a full-time bona fide employee working solely for the contractor) to solicit or secure this contract, and they have not paid or agreed to pay any company or person (other than a full-time bona fide employee working solely for the contractor) any fee, commission percentage or brokerage fee contingent upon or resulting from the award of this contract.

k. They (check one) operate ___an individual; _____a Partnership ____a non-profit (501 C-3) organization; _____a not-for-profit organization; or _____for Profit Corporation, incorporated under the laws of the State of_____.

l. The referenced bidder has neither directly or indirectly entered into any agreement, participated in any collusion or otherwise taken any action in restraint of free competitive

bidding in connection with this bid submitted this date to Delaware Health and Social Services.

m. The referenced bidder agrees that the signed delivery of this bid represents the bidder's acceptance of the terms and conditions of this invitation to bid including all specifications and special provisions.

n. They (check one): _____are; _____are not owned or controlled by a parent company. If owned or controlled by a parent company, enter name and address of parent company:

_____
_____
_____
_____

Violations and Penalties:

Each contract entered into by an agency for professional services shall contain a prohibition against contingency fees as follows:

1. The firm offering professional services swears that it has not employed or retained any company or person working primarily for the firm offering professional services, to solicit or secure this agreement by improperly influencing the agency or any of its employees in the professional service procurement process.
2. The firm offering the professional services has not paid or agreed to pay any person, company, corporation, individual or firm other than a bona fide employee working primarily for the firm offering professional services, any fee, commission, percentage, gift, or any other consideration contingent upon or resulting from the award or making of this agreement; and
3. For the violation of this provision, the agency shall have the right to terminate the agreement without liability and at its discretion, to deduct from the contract price, or otherwise recover the full amount of such fee, commission, percentage, gift or consideration.

The following conditions are understood and agreed to:

a. No charges, other than those specified in the cost proposal, are to be levied upon the State as a result of a contract.

b. The State will have exclusive ownership of all products of this contract unless mutually agreed to in writing at the time a binding contract is executed.

Date Signature & Title of Official Representative

_____
Type Name of Official Representative

PROCUREMENT

STATEMENT OF COMPLIANCE

As the official representative for the contractor, I

Certify that on behalf of the agency that _____

(Company name) will comply with all federal and State of Delaware laws, rules, and regulations, pertaining to equal employment opportunity and affirmative action laws. In addition, compliance will be assured in regard to federal and State of Delaware laws and Regulations relating to confidentiality and individual and family privacy in the collection and reporting of data.

Authorized Signature: _____

Title: _____

Date: _____

P ATTACHMENT P: MANDATORY SUBMISSION REQUIREMENTS CHECKLIST

DHSS has provided below the template for the Bid Proposal Mandatory Requirements Checklist that is to be submitted with the Technical Proposal portion of Bid Proposals. Bidders are expected to confirm compliance by entering "Yes" in the Bidder Check column. Upon receipt of Bid Proposals, DHSS will confirm compliance by entering "Yes" in the DHSS column.

Bid Proposal Mandatory Requirements Checklist

Bidder Name:				
MANDATORY REQ. #	**REQUIREMENT**	**RFP Section #**	**BIDDER CHECK**	**DHSS CHECK**
1.	Did the Bidder submit a Letter of Interest to Bid by June 14, 2013 at 9:00 a.m. ET?	2.2		
2.	Did the Bidder have a representative attend the Mandatory Bidder's Meeting on June 14, 2013 at 9:00 a.m. ET?	2.3		
3.	Have all Bid Proposal materials been submitted to the Issuing Officer on or before specified submission deadline of August 7, 2013 at 11:00 a.m. ET?	5.1.1 5.1.2		
4.	Does each Bid Proposal consist of three distinct parts labeled as: Disk Number 1: *Technical Proposal*, *Disk Number 2: Cost Proposal* *Disk Number 3: Corporate Confidential Information*?	5.1		
5.	Are there two original sets of disks labeled as "Original" and six disk sets labeled as "Copy"?	5.1		
6.	Is Disk Number 2: Cost Proposal submitted in a sealed envelope?	5.1		
7.	Are all disks labeled on the outside with the following information? State of Delaware Department of Health and Social Services RFP ***Delaware Medicaid Enterprise System Procurement*** **Disk number 1, 2, or 3** Technical Proposal, Cost Proposal, or Corporate Confidential Information DHSS RFP # HSS-*13-012* (Name of Bidder**)** August 7, 2013	5.1		

Bidder Name:				
MANDATORY REQ. #	**REQUIREMENT**	**RFP Section #**	**BIDDER CHECK**	**DHSS CHECK**
8.	Are the disks either in CD-R or DVD-R format?	5.1		
9.	Proposal disks have been scanned and are free from viruses and other malicious software.	5.1		
10.	Does Disk Number 1 contain, at a minimum, the following files? • Disk Directory.doc (Microsoft Word 2000 or higher) • RFP Technical Proposal.doc • RFP Technical Proposal.pdf • RFP Project Schedule.mpp	5.1		
11.	Does Disk Number 2 contain, at a minimum, the following files? • Disk Directory.doc (Microsoft Word 2000 or higher) • RFP Cost Proposal.doc • RFP Cost Proposal.pdf	5.1		
12.	Does Disk Number 3 contain, at a minimum, the following files? • Disk Directory.doc (Microsoft Word 2000 or higher) • Corporate confidential information in PDF format • Corporate confidential information in Microsoft Word (.doc) format (as necessary)	5.1		
13.	Do the paper copies of the Technical and Cost Proposal meet the following guidelines? • Submitted on 8.5” x 11’ paper • Printed double-sided	5.1		
14.	Are materials for each *Technical Proposal* presented in a three-ring binder or similar binding that allows for easy removal of documents separate from the sealed *Cost Proposal* materials?	5.1		
15.	Are materials for each *Cost Proposal* presented in a 3-ring binder or similar binding that allows for easy removal of documents?	5.1		
16.	If the submitted proposal contains trade secrets or other proprietary data, is it conspicuously marked on the cover sheet as containing confidential information?	5.1		
17.	Does each Bid Proposal package include one original and three copies of the	5.1		

Bidder Name:				
MANDATORY REQ. #	**REQUIREMENT**	**RFP Section #**	**BIDDER CHECK**	**DHSS CHECK**
	Technical Proposal in a separate binder (or set of binders)? Are the original and copies correctly marked?			
18.	Does each *Cost Proposal* package include one original and two copies (in separate sealed envelopes)? Are the original and copies correctly marked? (NOTE: *This will be determined when Cost Proposals are opened after the Technical Proposals have been evaluated*.)	5.1		
19.	Is each Bid Proposal sealed in a package (or packages), with *Cost Proposal* and the *Corporate Confidential Information* portions sealed in separate, labeled envelopes?	5.1		
20.	Are packing boxes numbered in the following fashion: 1 of 4, 2 of 4, etc., for each Bid Proposal that consists of multiple boxes	5.1		
21.	Are all boxes containing bids labeled with the following information? ▪ Bidder's Name and Address ▪ Procurement Officer Name and Department's Address RFP Title and RFP Reference Number	5.1		
TECHNICAL PROPOSAL CONTENTS (Disk Number 1)				
22.	Does each *Technical Proposal* consist of the following sections separated by tabs with associated documents and responses presented in the following order? ▪ Tab 1 Table of Contents ▪ Tab 2 Transmittal Letter and Executive Summary ▪ Tab 3 Requirements Checklist ▪ Tab 4 Required Forms ▪ Tab 5 Understanding the Teaming Approach of the Delaware Medicaid Enterprise System ▪ Tab 6 Corporate Background and Experience ▪ Tab 7 Project Management Oversight and Planning ▪ Tab 8 Technical Approach to Design Development, and Testing ▪ Tab 9 Technical Approach to Implementation and Training ▪ Tab 10 Technical Approach to Fiscal Agent Operations	5.2		5.2

Bidder Name:				
MANDATORY REQ. #	**REQUIREMENT**	**RFP Section #**	**BIDDER CHECK**	**DHSS CHECK**
	▪ Tab 11 Technical Approach to System Operation and Maintenance Support ▪ Tab 12 Technical Approach to Certification ▪ Tab 13 Management Approach to Contractor Staffing ▪ Tab 14 Technical Approach to Turnover ▪ Tab 15 Technical Approach to Enterprise Architecture			
23.	For each original and copy of the Technical Proposal, does the Table of Contents appear as Tab 1 and does it identify all Sections, subsection(s), and corresponding page numbers for each disk?	5.2.1		
24.	For each original and copy of the Technical Proposal, does the Transmittal Letter appear on company letterhead as Tab 2?	5.2.2		
25.	Is the Transmittal Letter signed by an individual authorized to commit the company to the Statement of work proposed?	5.2.2		
26.	Does the Transmittal Letter include the following statements in the order displayed below?	5.2.2		
27.	1. A statement acknowledging that the State will not accept any exceptions to the requirements of the RFP, the attachments, and the terms and conditions of the proposed Agreement.	5.2.2		
28.	2. A statement that the Bidder acknowledges and understands that alternative or contingent proposals will not be accepted.	5.2.2		
29.	3. A statement indentifying all subcontractors, the work to be completed by the Contractor and each subcontractor as a percentage of the total work to be performed. The Technical Proposal must not include actual price information. Such inclusion may result in rejection of the proposal.	5.2.2		
30.	4. A statement providing the corporate charter number and assurances that	5.2.2		

Bidder Name:				
MANDATORY REQ. #	**REQUIREMENT**	**RFP Section #**	**BIDDER CHECK**	**DHSS CHECK**
	any subcontractor proposed is also licensed to work in Delaware.			
31.	5. A statement identifying both the Bidder and its subcontractor's federal tax identification numbers.	5.2.2		
32.	6. A statement of affirmative action that the Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap.	5.2.2		
33.	7. A statement identifying all addenda to this RFP issued by the State and received by the Bidder. If no addenda have been received, a statement to that effect shall be included.	5.2.2		
34.	8. A statement that the Bidder certifies in connection with this procurement that: a. A statement that the person signing this letter certifies that he/she is the person in the Bidder's organization responsible for, or authorized to make, decisions regarding the prices quoted and that he/she has not participated, and will not participate, in any action contrary to item (1) above.	5.2.2		
35.	b. If the use of subcontractor(s) is proposed, a statement from each subcontractor on their letterhead must be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor stating: i. The general Statement of work to be performed by the subcontractor. ii. The subcontractor's willingness to perform the work indicated. iii. The subcontractor's assertion that it does not discriminate in employment practices with	5.2.2		

Bidder Name:				
MANDATORY REQ. #	**REQUIREMENT**	**RFP Section #**	**BIDDER CHECK**	**DHSS CHECK**
	regard to race, color, religion, age (except as provided by law), sex marital status, political affiliation, national origin, or handicap.			
36.	c. A statement that the Bidder will not use, or propose to use, any offshore services in fulfilling the requirements outlined in this RFP and in the attached Model Contract.	5.2.2		
37.	For each original and copy of the Technical Proposal, does the Executive Summary appear as Tab 2?	5.2.2		
38.	Is the Executive Summary 10 pages or less?	5.2.2		
39.	For each original and copy of the Technical Proposal, is a completed copy of the *Mandatory Requirements Checklist* included in Tab 3?	5.2.3		
40.	For each original and copy of the Technical Proposal, is the completed RFP Crosswalk included in Tab 3?	5.2.3		
41.	For each original and Technical Proposal, is the completed HIPAA Compliance Matrix included in Tab 3?	5.2.3		
42.	Did the Bidder include and sign and date the Certification and Statement of Compliance form in Tab 4?	5.2.4		
43.	Did the Bidder include Named Position Resumes using the required forms in Tab 4?	5.2.4		
44.	Did the Bidder include the State of Delaware Contracts Disclosure form in Tab 4?	5.2.4		
45.	Did the Bidder include and fill out the Bidders Signature Form in Tab 4?	5.2.4		
46.	Did the Bidder include and fill out the Office of Minority and Women Business Enterprise Self-Tracking Form in Tab 4?	5.2.4		
47.	Did the Bidder include and fill out the Bidder Project Experience Form in Tab 4?	5.2.4		
48.	Did the Bidder include and fill out the Bidder Contact Information in Tab 4?	5.2.4		
49.	Did the Bidder include and fill out the Personal Reference Form in Tab 4?	5.2.4		

Bidder Name:				
MANDATORY REQ. #	**REQUIREMENT**	**RFP Section #**	**BIDDER CHECK**	**DHSS CHECK**
COST PROPOSAL CONTENTS (Disk Number 2)				
50.	Does each *Cost Proposal* consist of the following sections separated by tabs with associated documents and responses presented in the following order? ▪ Tab 1: Table of Contents ▪ Tab 2: Project Cost Forms, Pricing Schedules A through F, Appendix K ▪ Tab 3: Software and Hardware Information	5.3.1		
51.	For each original and copy of the Cost Proposal, does the Table of Contents appear as Tab 1 and does it identify all Sections, subsection(s), and corresponding page numbers?	5.3.2		
52.	For each original and copy of the Cost Proposal, are the following pricing schedules included in Tab 2? • Summary of Total Proposal (Pricing Schedule A) • DMES/POS PBM System Planning, Design, Development, Testing and Implementation Price Components from Contract Award (Pricing Schedules B and D) • DMES/POS PBM System Planning, Design Development, Testing and Implementation Milestone Payments (Pricing Schedules B-1 and D-1) • DMES/POS PBM Operational Pricing Summary (Pricing Schedules C and E) • DMES/POS PBM Operational Price Components (Pricing Schedules C1-C5 and E1-E5) • Staffing Rate Card (Schedule F)	5.3.4		
53.	Are the Pricing Schedules in the required formats?	5.3.4.1		
54.	For each original and copy of the Cost Proposal, has a preliminary list of hardware been included in Tab 3 of the cost proposal?	5.3.5		
55.	For each original and copy of the Cost Proposal, has a preliminary list of software been included in Tab 3 of the cost proposal?	5.3.5		

Bidder Name:				
MANDATORY REQ. #	**REQUIREMENT**	**RFP Section #**	**BIDDER CHECK**	**DHSS CHECK**
CORPORATE CONFIDENTIAL INFORMATION (Disk Number 3)				
56.	For each original and copy of the Corporate Confidential Information are audited financial statements (annual reports) for the last 3 years included?	5.4		
57.	For each original and copy of the Corporate Confidential Information is there at least three financial references (e.g., letters from creditors, letters from banking institutions, Dun & Bradstreet supplier reports) included?	5.4		
58.	For each original and copy of the Corporate Confidential Information is a description of other contracts or projects currently undertaken by the Bidder included?	5.4		
59.	For each original and copy of the Corporate Confidential Information is a summary of any pending or threatened litigation, administrative or regulatory proceedings, or similar matters that could affect the ability of the Bidder to perform the required services included?	5.4		
60.	For each original and copy of the Corporate Confidential Information has the Bidder included a disclosure of any contracts during the preceding 5 year period, in which the Bidder or any subcontractor identified in the Bid Proposal, defaulted?	5.4		
61.	For each original and copy of the Corporate Confidential Information has the Bidder included a disclosure of any contracts during the preceding 5 year period, in which the Bidder or any subcontractor identified in the Bid Proposal terminated a contract prior to its stated term or has had a contract terminated by the other party prior to its stated term?	5.4		
62.	Did the bidder include and fill out Service Provider Authorization and corresponding table in section L.3	L.3		
63.	Did the bidder include and fill out Acknowledgement of Terms and Conditions in section L.4	L.4		

The table below is a template for the crosswalk of requirements in the RFP. Bidders are required to fill out this crosswalk completely for each section. It links the identified RFP sections to the sections and page numbers of the Bidder's proposal.

RFP Crosswalk

RFP Section	Proposal Section Number	Proposal Page Number(s)
Attachment B – Statement of Work		
Contractor General Responsibilities		
Project Staffing		
Project Deliverables		
Role of the QA Contractor		
Implementation Strategy		
On-Site Staffing Requirement		
Offsite Project Work		
Offshore Project Work		
Facilities and Equipment		
Task 1 – Project Management		
Task 2 – Detailed Requirements Analysis		
Task 3 – Design		
Task 4 – Development		
Task 5 – Data Conversion		
Task 6 – Acceptance Testing		
Task 7 – Training		
Task 8 – Implementation		
Task 9 – Operations – Fiscal Agent Services		
Task 10 – Certification		
Task 11 – Systems Operations and Maintenance Support		
Task 12 – Operations – Pharmacy Benefit Management Services		
Task 13 – Turnover		
Attachment C – DMES Functional Requirements		
CMS Certification		
Compliance with Federal Standards		
HIPAA Regulations and Standards		
State Policies and Standards		
CMS Enhanced Funding Requirements		
System Documentation		

RFP Section	Proposal Section Number	Proposal Page Number(s)
Architecture Requirements		
Delaware MITA Objectives		
Service Oriented Architecture		
Software Licenses and Maintenance		
Software Escrow		
Change Control		
Records Retention		
System Testing		
Degree of Customization		
Deliverable Standards		
Contract Accounting Requirements		
Payment for Pass-Through Items		
Auditing Requirements		
Core Functions		
Pharmacy Benefits Management		
Supporting Modules and System Components Outside the Core		
Attachment D – DMES Systems Operations and Maintenance Tasks		
Support Services		
Maintenance Services		
Maintaining the DMES		
System Change Category Descriptions		
Systems Team Staffing/Programming Hours		
Project Help Desk Staff Requirement		
Attachment E – Deliverables		
1.1 – Project Plan		
1.2 – Project Plan Updates		
1.3 – Change Management Plan		
1.4 – Software Development Methodology		
1.5 – Project Repository		
1.6 – Project Status Reporting		
1.7 – Security Policies and Procedures		
1.8 & 6.7 – Business Continuity Plan		
2.1 – Detailed Requirements Specification		
3.1, 4.6, 6.8 & 8.6 – Detailed System Design Versions 1, 2		

RFP Section	Proposal Section Number	Proposal Page Number(s)
3 & 4		
3.2, 4.7, & 8.1 – Implementation Plan, Versions 1, 2 & 3		
3.3 – System Architecture and Design Document		
3.4 – Architectural Review Board Requirements		
3.5 – Test Management Plan		
3.6 – Network Upgrade Requirements		
3.7 – Data Conversion Strategy		
4.1 – Development Environment		
4.2, 6.6 & 8.3 – Code Library, Versions 1, 2 & 3		
4.3 & 6.3 – Development Test Results		
4.4 & 8.4 – User Manual, Versions 1 & 2		
4.5 & 8.5 – Operating Procedures, Versions 1 & 2		
5.1 – Data Conversion Plan		
5.2 – Conversion Test Results		
6.1 – Test Environment		
6.2 – Acceptance Test Plan		
6.3 – Acceptance Test Results		
6.4 – Operational Readiness Testing Plan		
6.5 – Operational Readiness Test Results		
7.1 – Training Strategy		
7.2 – Training Plan		
7.3 – Training Environment		
7.4 – Training Materials		
7.5 – Training Report		
8.2 – Production Environment		
8.7 – Implementation Certification Letter		
9.1 & 12.1 – Operations Quality Management Plan		
9.2 & 12.2 – Fiscal Agent Staffing Requirements Capability Report		
9.3, 11.3 & 12.3 – Weekly Project Status Report		
9.4, 11.4 & 12.4 – Annual Status Report		
10.1 – Certification Checklist		
10.2 – Certification Review Package		
11.1 – System Operation & Maintenance Support Plan		
11.2 – Staffing Requirements Capability Report		
11.5 – System Updates		

RFP Section	Proposal Section Number	Proposal Page Number(s)
11.6 – Operations and Maintenance Procedure Manual		
13.1 – Turnover Plan		
13.2 – Develop a DMES Requirements Statement		
13.3 – Systems Documentation and Source Code Library		
13.4 – Turnover Results Report		

Q ATTACHMENT Q: DELAWARE CONTRACTS DISCLOSURE FORM

STATE OF DELAWARE CONTRACTS DISCLOSURE

Contractor/ Predecessor Firm Name	State Department and Division	Contact Name, Address, and Phone Number	Period of Performance	Contract Number	Amount
Sample Contractor Firm Name	DHSS \ DMS	Contact Name 1901 N DuPont Highway New Castle, DE 19720 302.999.9999	01/01/2002 – 12/31/2002	HSS-99-999	$100,000

Bidder shall list all contracts awarded to it or its predecessor firm(s) by the State of Delaware during the last 3 years by State Department, Division, Contact Person (with address/phone number), period of performance, contract number, and amount. The Evaluation/Selection Review Committee will consider these additional references and may contact each of these sources. Information regarding Bidder performance gathered from these sources may be included in the Committee's deliberations and factored in the final scoring of the bid. Failure to list any contract as required by this paragraph may be grounds for immediate rejection of the bid.

List contracts in the format specified. Include those contracts whose period of performance has been within the past 3 years in addition to those awarded within this timeframe. Contracts with amendments only have to be listed once. If a Contractor has had no contracts within this timeframe, enter "**No contracts to specify**" under Contractor/Predecessor Firm Name in the first row of the table.

R ATTACHMENT R: BIDDER'S SIGNATURE FORM

DELAWARE HEALTH AND SOCIAL SERVICES

REQUEST FOR PROPOSAL

BIDDER'S SIGNATURE FORM

NAME OF BIDDER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

TYPE IN NAME OF AUTHORIZED PERSON: _____

TITLE OF AUTHORIZED PERSON: _____

STREET NAME AND NUMBER: _____

CITY, STATE, & ZIP CODE: _____

CONTACT PERSON: _____

TELEPHONE NUMBER: _____

FAX NUMBER: _____

DATE: _____

BIDDER'S FEDERAL EMPLOYERS IDENTIFICATION NUMBER: _____

DELIVERY DAYS/COMPLETION TIME: _____

F.O.B.: _____

TERMS: _____

THE FOLLOWING MUST BE COMPLETED BY THE CONTRACTOR:

AS CONSIDERATION FOR THE AWARD AND EXECUTION BY THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES OF THIS CONTRACT, THE (COMPANY NAME)_____HEREBY GRANTS, CONVEYS, SELLS, ASSIGNS, AND TRANSFERS TO THE STATE OF DELAWARE ALL OF ITS RIGHTS, TITLE AND INTEREST IN AND TO ALL KNOWN OR UNKNOWN CAUSES OF ACTION IT PRESENTLY HAS OR MAY NOW HEREAFTER ACQUIRE UNDER THE ANTITRUST LAWS OF THE UNITED STATES AND THE STATE OF DELAWARE, RELATING THE PARTICULAR GOODS OR SERVICES PURCHASED OR ACQUIRED BY THE DELAWARE HEALTH AND SOCIAL SERVICES DEPARTMENT, PURSUANT TO THIS CONTRACT.

S ATTACHMENT S: OFFICE OF MINORITY AND WOMEN BUSINESS ENTERPRISE CERTIFICATION TRACKING FORM

OFFICE OF MINORITY AND WOMEN BUSINESS ENTERPRISE SELF-CERTIFICATION TRACKING FORM

IF YOUR FIRM WISHES TO BE CONSIDERED FOR ONE OF THE CLASSIFICATIONS LISTED BELOW, THIS PAGE MUST BE SIGNED, NOTARIZED AND RETURNED WITH YOUR PROPOSAL.

COMPANY NAME: _____

NAME OF AUTHORIZED REPRESENTATIVE (Please print): _____

SIGNATURE: _____

COMPANY ADDRESS: _____

TELEPHONE #: _____

FAX #: _____

EMAIL ADDRESS: _____

FEDERAL EI#: _____

STATE OF DE BUSINESS LIC#: _____

Note: Signature of the authorized representative must be of an individual who legally may enter his/her organization into a formal contract with the State of Delaware, Delaware Health and Social Services.

Organization Classifications (Please circle)
Women Business Enterprise (WBE) Yes/No
Minority Business Enterprise (MBE) Yes/No
Please check one---Corporation: _____ Partnership: _____Individual: _____

For appropriate certification (WBE), (MBE), (DBE) please apply to Office of Minority and Women Business Enterprise Phone # (302) 739-4206 L. Jay Burks, Executive Director Fax# (302) 739-1965
http://gss.omb.delaware.gov/osd/index.shtml

Certification #_____ Certifying Agency_____

SWORN TO AND SUBSCRIBED BEFORE ME THIS _____ DAY OF _____20____

NOTARY PUBLIC_____MY COMMISSION EXPIRES _____

CITY OF _____COUNTY OF _____STATE OF_____

Definitions

The following definitions are from the State Office of Minority and Women Business Enterprise.

Women Owned Business Enterprise (WBE):
At least 51 percent is owned by women, or in the case of a publicly owned enterprise, a business enterprise in which at least 51 percent of the voting stock is owned by women; or any business enterprise that is approved or certified as such for purposes of participation in contracts subject to women-owned business enterprise requirements involving federal programs and federal funds.

Minority Business Enterprise (MBE):
At least 51% is owned by minority group members; or in the case of a publicly owned enterprise, a business enterprise in which at least 51 percent of the voting stock is owned by minority group members; or any business enterprise that is approved or certified as such for purposes of participation in contracts subjects to minority business enterprises requirements involving federal programs and federal funds.

Corporation:
An artificial legal entity treated as an individual, having rights and liabilities distinct from those of the persons of its members, and vested with the capacity to transact business, within the limits of the powers granted by law to the entity.

Partnership:
An agreement under which two or more persons agree to carry on a business, sharing in the profit or losses, but each liable for losses to the extent of his or her personal assets.

Individual:
Self-explanatory

For certification in one of above, the Bidder must contact:

L. Jay Burks
Office of Minority and Women Business Enterprise
(302) 739-4206
Fax (302) 739-1965

T ATTACHMENT T: BIDDER PROJECT EXPERIENCE

Bidder Project Experience

Client	
Contact Name	
Telephone No.	
Location Street Address	
Location City/State/ZIP	
Type of Facility	
Comparable Project Experience	
Current Status (Work in Progress/Complete)	
Original Budget	
Completed Budget	
Original Schedule	
Completed Schedule	
Comments:	
Use one page per client. All clients will be used as references and all projects must be completed or work in progress. For projects in progress, state the estimated final budget and schedule dates based on current status. The Contact must be an administrative or managerial customer reference familiar with the Bidder's performance.	

U ATTACHMENT U: DELIVERABLE ACCEPTANCE REQUEST FORM

DELAWARE HEALTH
AND SOCIAL SERVICES

Deliverable Acceptance Request (DAR)

Division Name:	
Project Name:	
Project Phase:	
Project Manager:	
Contractor:	
Contractor Project Manager:	

Deliverable Name:	
Delivery Date:	
Expected Date of Response:	
Actual hours worked and Cost incurred:	

Narrative of findings:

Division Program Name:	Signature:	Date:
Division Information Technology (IT) Liaison Name:	Signature:	Date:
Information Resource Management (IRM) Name:	Signature:	Date:

V ATTACHMENT V: BIDDER CONTACT INFORMATION

Delaware Health and Social Services
Request for Proposal

Bidder Contact Information

The following information must be filled out for firms interested in bidding on this Request for Proposal (RFP). This letter has a strict submission deadline date prior to the submission of a proposal. Proposals submitted without prior submission of this form will not be opened. Multiple Bidder contacts may be specified.

Bidder Contact(s)

Contact Name	
Email Address	

Authorized Contractor Representative

Printed Name	
Signature	
Phone Number	

W ATTACHMENT W: NAMED STAFF RESUME

Named Staff Resume

Name:_____ Proposed Project Position:_____

Number of years experience in the proposed position:_____

Number of years experience in this field of work:_____

Detail Training/Education
(Repeat the format below for as many degrees/certificates as are relevant to this proposal. Dates between training/education may overlap.)

Degree/Certificate Dates of Training/Education

Detail Experience
(Repeat the format below for as many jobs/projects as are relevant to this proposal. Dates between jobs/projects may overlap.)

Job/Project:_____ Position:_____

From Date:_____ To Date:_____

Description of the tasks this person performed in this job/project. Detail any state or government planning projects and specify the role of the person on each project

X ATTACHMENT X: PERSONAL REFERENCE FORM

Personal Reference Form

Provide all information requested.

NAME OF EMPLOYEE:	
REFERENCE FIRM/AGENCY NAME:	
COMPLETE ADDRESS	
CONTACT INFORMATION (name title)	
CONTACT PHONE NUMBER	
CONTACT EMAIL ADDRESS	
POSITION OF INDIVIDUAL WITHIN THE PROJECT ORGANIZATION	
PROJECT BEGIN DATE	
PROJECT END DATE	
BRIEF DESCRIPTION OF INDIVIDUAL'S RESPONSIBILITIES	

THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK