



Solicitation Information

22 November 11

RFP #7449255

TITLE: Request for Proposals for Transition, Enhancement, Operation, and Maintenance of the Medicaid Management Information System

Submission Deadline: 6 February 2012 @ 11:30 AM(Eastern)

PRE-BID/PROPOSAL CONFERENCE: Yes

Date: 7 December 2011 Time: 1:30 PM (Eastern)

Mandatory: Yes

Location: Department of Administration/Division of Purchases, 2nd Floor Bid Room, One Capitol Hill, Providence, RI

Questions concerning this solicitation must be received by the Division of Purchases at questions@purchasing.ri.gov no later than 19 December 2011 @ 12:00 Noon (Eastern). Questions should be submitted in a *Microsoft Word attachment*. Please reference the RFP # on all correspondence. It is the responsibility of all interested parties to download this information.

SURETY REQUIRED: No

BOND REQUIRED: No

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Assistant Director for Special Projects**

Vendors must register online at the State Purchasing Website at www.purchasing.ri.gov

THIS PAGE IS NOT A BIDDER CERTIFICATION FORM

NOTE TO VENDORS:

Offers received without the entire completed three-page RIVIP Generated Bidder Certification Form attached may result in disqualification.

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1. Overview of the Procurement

The State of Rhode Island is issuing this Request for Proposals (RFP) to: 1) procure a Fiscal Agent (FA) Contractor to take over the current Medicaid Management Information System (MMIS) and related systems; 2) operate and maintain all current functionality; 3) implement enhancements to current functionality 4) modify the MMIS and related systems as requested by the State; and 5) at the end of the contract, turn the systems over to the State or its designated contractor. The MMIS is critical to the State's ongoing operations. The State is seeking a Contractor that will be able to transfer the operation and maintenance of MMIS without degrading the system's current level of performance and quality.

The base contract term is five (5) years with an option for three (3) one-year contract extensions at the State's discretion.

1.1. Procurement Authority

This RFP is issued under the authority of the General Laws of the State of Rhode Island (R.I.G.L.), Title XIX of the Social Security Act, as amended, and the implementing regulations issued under that authority. Any proposal submitted by any prospective FA that fails to meet any published requirement may, at the option of the State, be rejected without further consideration.

Vendors must register online at the State Purchasing Website at www.purchasing.ri.gov.

Offers received without the entire completed three-page Rhode Island Vendor Information Program (RIVIP) Generated Bidder Certification Form attached may result in disqualification.

The contact for all Bidder communications with the State in regard to this procurement is:

Mr. Jerome Moynihan, C.P.M., CPPO
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1.2. Procurement Schedule

The anticipated procurement schedule is shown in the following table.

Table 1: Procurement Schedule

Activity	Anticipated Date
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Activity	Anticipated Date
RFP Issued	November 22, 2011
Mandatory Bidder's Conference	December 7, 2011 (1:30 PM ET)
Notice of Intent to Submit a Proposal Due	December 12, 2011 (1:00 PM ET)
Closing Date for Written Questions	December 19, 2011 (3:00 PM ET)
Responses Posted to Bidder's Conference Questions	January 3, 2012
Addendum to RFP Posted (if necessary)	January 9, 2012
Closing Date for Receipt of MMIS Proposals/Bid Opening	February 4, 2012 (3:00 PM ET)
Oral Presentations	February 2012 (TBD)
Bidder Selection; Notification of Intent to Award MMIS FA Contract	March 22, 2012

1.3. Procurement Objectives and Scope

The Rhode Island Medicaid Program operates within the Executive Office of Health and Human Services (EOHHS), which administers Rhode Island's health and social service programs. Rhode Island Medicaid operates under a Section 1115 demonstration waiver, known as the Global Waiver.

Rhode Island Medicaid has been requested to undertake this activity in accordance with the Rhode Island Department of Administration (DoA) Office of Purchases provisions that all State contracts be competitively bid in order to minimize the sole sourcing of external services to a single vendor without timely re-bidding of such services.

While the current MMIS operates in a highly functional fashion, technological advancements and enhancements in this environment support the need for a re-procurement effort. The Successful Bidder will be required to implement the functional and technical enhancements described in Sections 6 and 7 of this RFP.

The Successful Bidder will also be required to take over, operate and maintain all current functions and operations of the Rhode Island MMIS. These responsibilities include processing of claims and other transactions for the following entities:

- EOHHS;
- Department of Human Services (DHS);
 - o Division of Elderly Affairs (DEA);
- Department of Health (DOH);
- Department of Children, Youth and Families (DCYF);

- Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH); and
- Department of Corrections (DOC).

Claims and other transactions processed for these agencies include: claims and encounters processed for Medicaid eligibles and other populations covered by the 1115 Global Waiver; claims for clients who participate in the same programs but whose Medicaid eligibility varies; claims for clients who participate in programs covered under programs for Costs Not Otherwise Matchable (CNOMs) as approved under the Global Waiver; and other medical and social services claims for populations managed by the above departments and agencies.

The Successful Bidder will be required to transition, operate, and maintain other operational functions currently performed by the MMIS FA. These functions include, but are not limited to: 1) operation of the Data Warehouse; 2) operation of the provider Web portal, including provider enrollment, various call centers, pharmacy point-of-sale processing, encounter processing for multiple managed care programs, prior authorization of services, translation services, third-party liability identification, and estate and casualty recoveries; and 3) premium payment generation and collection. The Successful Bidder is required to maintain current operations and implement enhancements to maintain Centers for Medicare and Medicaid Services (CMS) certification of the MMIS required to achieve the maximum federal financial participation (FFP) allowed.

The State has attempted to document all current functionality in the Bidders' Library; however, the Successful Bidder is required to assume all functionality regardless of inclusion in the Library. Bidders should use their expertise in MMIS, Data Warehouse, and FA Services to ensure that any additional requirements for the transition, operation, and maintenance of the MMIS, Data Warehouse, and FA services beyond those stated by EOHHS are included and considered in all aspects of their proposal. Bidders are responsible for considering all transition responsibilities and submitting questions to clarify any responsibilities in question.

In addition to other documents, the Bidders' Library includes descriptions of current Medicaid functionality as defined by the Medicaid Information Technology Architecture (MITA) business functions, resulting from the State's MITA State Self-Assessment (MITA SS-A) conducted in 2011. The relevant sections of the MITA SS-A are included in the Bidders' Library for reference by Bidders.

This RFP addresses use of the current CMS-approved versions of the CMS Medicaid Enterprise Certification Toolkit Checklists throughout the procurement, implementation, and certification activities included under the Contract resulting from this procurement to describe the functionality that must be part of the transition, operation, maintenance, and enhancement of the MMIS and related systems. The functionality includes CMS and State-specific business objectives. Checklists are included in Appendix O.4 to this RFP.

The Successful Bidder is required to support the State's Enterprise Application Architecture Strategy for the long-term improvement of its enterprise systems and technical capabilities as part of the transition, enhancement, operation, and maintenance activities. This strategy is described in Section 7 of this RFP. Bidders are expected to review the strategy, as well as documentation included in the Bidders' Library, and to use their expertise in MMIS, Data Warehouse, and FA Services to ensure that any additional technical requirements beyond those stated by EOHHS are included and considered in all aspects of their proposal. Bidders are responsible for submitting questions to clarify any responsibilities in question.

1.4. Organization of the RFP

The remainder of this RFP is organized into the following sections:

- Section 2: Procurement Rules
- Section 3: Description of Rhode Island Medical Assistance and Related Programs
- Section 4: Proposal Submission Requirements
- Section 5: Statement of Work
- Section 6: Functional Requirements
- Section 7: Technical Requirements
- Section 8: Evaluation and Selection
- Section 9: Contract Terms and Conditions
- Appendices:
 - A. State's General Conditions of Purchase
 - B. Notice to Executive Office of Health and Human Service Providers of Their Responsibilities under Title VI of the Civil Rights Act of 1964
 - C. Notice to Executive Office of Health and Human Services Service Providers of Responsibilities under Section 504 of the Rehabilitation Act of 1973
 - D. Drug-Free Workplace Policy and Fiscal Agent Certificate of Compliance
 - E. Subcontractor Compliance
 - F. Certification Regarding Environmental Tobacco Smoke
 - G. Instructions for Certification Regarding Debarment, Suspension, and Other Responsibility Matters – Primary Covered Transactions and Certification
 - H. W9 Form
 - I. Glossary of Acronyms
 - J. Service Level Agreements

- K. List of CNOMs
- L. Contents of the Bidders' Library
- M. Mandatory Proposal Submission Requirements Checklists
 - M.1. Mandatory Technical Proposal Requirements Checklist
 - M.2. Mandatory Cost Proposal Requirements Checklist
- N. Cost Proposal Schedules
- O. Bidder Acknowledgment Checklists
- P. Medicaid Enterprise Certification Toolkit Checklists

2. Procurement Rules

This section includes Rhode Island's rules for the procurement of a FA to transition, enhance, operate, and maintain the Rhode Island MMIS.

Vendors must register online at the State Purchasing Website at www.purchasing.ri.gov.

Offers received without the entire completed three-page RIVIP Generated Bidder Certification Form may result in disqualification.

2.1. Procurement Authority

This RFP is issued under the authority of the General Laws of the State of Rhode Island (R.I.G.L.), Title XIX of the Social Security Act, as amended, and implementing regulations issued under the authority thereof. All prospective FAs are charged with presumptive knowledge of the requirements of the cited authorities. The submission of a valid executed proposal by any prospective FA shall constitute declaration of such knowledge on the part of each prospective FA. For further information regarding R.I.G.L. authority, please see:

<http://www.rilin.state.ri.us/Statutes/TITLE37/37-2/INDEX.HTM>

Any proposal submitted by any prospective FA that fails to meet any published requirement of the cited authorities may, at the option of EOHHS, be rejected without further consideration.

The anticipated procurement schedule is shown in the following table. All times in the table are Eastern Time (ET).

Table 2: Procurement Schedule

Activity	Anticipated Date
RFP Issued	November 22, 2011
Mandatory Bidder's Conference	December 7, 2011 (1:30 PM ET)
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Closing Date for Written Questions	December 19, 2011 (3:00 PM ET)
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Oral Presentations	February 2012 (TBD)
Bidder Selection; Notification of Intent to Award MMIS FA Contract	March 22, 2012

The State reserves the right to:

- Modify any date or deadline appearing in this RFP;
- Issue clarification notices, addenda, alternative RFP instructions, forms, and/or other relevant documentation;
- Waive any RFP requirement or instruction for all Bidders if the State determines that the requirement or instruction was unnecessary, erroneous, or unreasonable;
- Extend the proposal submission deadline; and/or
- Adjust or correct any clerical or mathematical errors occurring in this RFP.

2.2. Procurement Contact Information

Questions concerning this solicitation must be received by the Division of Purchases at questions@purchasing.ri.gov no later than 19 December 2011 @ 12:00 Noon (Eastern). Questions should be submitted in a Microsoft Word attachment. Please reference the RFP # on all correspondence. It is the responsibility of all interested parties to download this information.

2.3. Basic Qualification Criteria

To submit a proposal in response to this procurement, Bidders must meet the following minimum requirements:

- The Bidder must be the prime FA (not a subcontractor) for successful operation and maintenance of a state's certified MMIS for at least one (1) year;
- OR
- The Bidder must have been the prime FA for the successful implementation of a state's MMIS, for which certification was obtained.

2.4. Information to be Included in Proposals

Bidders must include all information as required in Section 4 of this RFP. The State may reject proposals that do not meet mandatory requirements.

2.5. Subcontracting

The Bidder may propose use of subcontractors to perform the work resulting from this procurement. Subcontractors must be identified and information on subcontractors must be included with proposals as required in Section 4 of this RFP. Terms and conditions applying to subcontractors are clearly stated in Section 8 of this RFP.

2.6. Mandatory Pre-Proposal Conference

A mandatory Pre-Proposal Conference will be held with prospective Bidders at 1:30 PM ET on December 7, 2011 at the following location:

Rhode Island Department of Administration
Division of Purchases Bid Room
2nd floor
1 Capitol Hill
Providence, RI 02903

Bidders may call (401) 574-8100 for directions to the conference site.

Attendance at the conference is required.

Questions submitted prior to or during the Pre-Proposal Conference will, to the extent possible, be discussed at the conference.

The State will determine which questions and responses will become part of the State's official position. Bidders should understand that the only official answer or position of the State is the one stated in writing. Verbal responses given at the Bidders' Conference are unofficial and are not binding unless later confirmed in writing and incorporated into an addendum to this RFP as stated in Section 2.8 of this RFP.

2.7. Letter of Intent to Submit a Proposal

Bidders are required to submit a Letter of Intent to submit a proposal. The Letter of Intent is due by December 12, 2011 at 1:00 PM ET. Letters of Intent must be submitted in writing via letter or fax to:

Mr. Jerome Moynihan, C.P.M., CPPO
Assistant Director for Special Projects
MMIS Procurement (RFP# 7449255)
Division of Purchases (2nd fl), Department of Administration
One Capitol Hill
Providence, Rhode Island 02908
Fax: (401) 222-6387

Letters of Intent may be submitted at the mandatory Pre-Proposal Conference.

Letters of Intent will not become public information until after the Closing Date and Time for Receipt of MMIS Proposals. The submission of a Letter of Intent is not binding on the prospective Bidder to submit a proposal.

Only those prospective Bidders who have submitted a Letter of Intent will receive subsequent notifications related to this RFP, including addenda and access to the electronic Procurement Library.

2.8. Submission of Written Questions

Bidders may submit written questions until December 19, 2011, 3:00 PM ET regarding the meaning or interpretation of the RFP provisions.

The RFP # must be referenced on all correspondence, including questions.

Questions concerning this solicitation must be received by the Division of Purchases at questions@purchasing.ri.gov no later than 19 December 2011 @ 12:00 Noon (Eastern). Questions should be submitted in a *Microsoft Word attachment*. Please reference the RFP # on all correspondence. It is the responsibility of all interested parties to download this information.

Bidders are strongly urged to submit questions as early as possible to allow the State sufficient time to answer questions.

Answers to written questions will be posted to the Internet at www.purchasing.ri.gov by January 3, 2012.

The written record of the conference and all other questions and answers will become a part of the RFP and released as an addendum to the solicitation. The RFP addendum will be posted to the Internet at www.purchasing.ri.gov by January 9, 2012.

Information given to a prospective Bidder concerning this procurement will be furnished promptly to all other prospective Bidders if that information is necessary in submitting offers or if the lack of it would be prejudicial to any other prospective Bidders. Information will be released, via addenda, and posted on the Internet at www.purchasing.ri.gov. It is the responsibility of all interested parties to scan the Website, on a frequent basis, for pertinent information. Any information available prior to the Pre-Proposal Conference will be provided at the conference.

Bidders shall notify the State immediately to report a known or suspected problem with this RFP. Bidders who fail to report a known or suspected problem with this RFP shall submit a proposal at their own risk.

2.9. Submission of Proposals

Proposals must conform to all proposal submission requirements as stated in Section 4 of this RFP. Failure to meet all requirements will place the Bidder at risk, and the State may reject the entire proposal.

2.10. Late Submissions, Modifications and Withdrawal of Proposals

Proposals and modifications of proposals will not be considered if received after the Closing Date and Time for Receipt of MMIS Proposals specified in Section 2.1 of this RFP.

A proposal submitted prior to the due date may be withdrawn by submitting a written request for withdrawal, signed by the Bidder's authorized agent, via letter or fax to Mr. Jerome D. Moynihan at the address or fax shown in Section 2.7 of this RFP.

In such cases, Bidders may submit an amended proposal before the final due date for receipt of proposals. Such amended proposals must be a complete replacement for any previously submitted proposal and must be clearly marked. The original (withdrawn) proposal will be returned unopened to the Bidder.

2.11. Alternate Proposals

A Bidder may not submit more than one proposal. Alternate proposals will not be accepted. A Bidder may be included in multiple proposals as a subcontractor.

2.12. Contacts with Bidders

Contact with individual Bidders may be made by the Evaluation Committee for the purpose of clarification or to correct minor discrepancies. Oral presentations or discussions with Bidders may be requested by the Evaluation Committee to explain or clarify significant elements of proposals.

2.13. State of Rhode Island Use of Proposal Ideas

The State of Rhode Island shall have the right to use any or all ideas presented in any proposal received in response to this RFP, unless the Bidder presents a positive statement of objection in the proposal. In no event shall such objection be valid with respect to the use of such ideas which are not the proprietary information of the Bidder and so designated in the proposal, or which:

- Were known to the State of Rhode Island before submission of such proposal;
- OR
- Properly became known to the State of Rhode Island after submission through other sources or through acceptance of the offer.

2.14. Award of Contract

The State of Rhode Island will award a contract to the responsible Bidder whose offer will be most advantageous to the State of Rhode Island, cost and other factors considered.

The State of Rhode Island may reject any or all offers or waive informalities and minor irregularities in offers to act in the State's best interest.

The State of Rhode Island may award a contract on the basis of initial offers received, without discussions or oral presentations.

Non-selection of any proposal will mean that another proposal was determined to be more advantageous to the State of Rhode Island or that no proposal was acceptable.

2.15. Contract Award Notification

All Bidders will be notified of the MMIS FA contract award when approved by the DoA Office of Purchases.

If the awarded Bidder fails to execute the Contract, the State may elect to cancel the award and begin the award process with the second highest ranked Bidder, assuming one exists and their proposal passed mandatory scoring requirements. The procurement process relative to this RFP shall not be officially closed until either a Contract is executed or the State otherwise moves to terminate the procurement.

2.16. Protest of Contract Award

Unsuccessful Bidders may protest the intent to award contract by submitting a certified letter to the Rhode Island Director of Purchasing within ten (10) calendar days of being notified. The letter must state the reason(s) for the protest and any remedies requested for resolution. Letters should be addressed to:

Lorraine Hynes
Acting Director
Division of Purchasing / Department of Administration
One Capitol Hill
Providence, RI 02908
Fax: 401 222-6378

2.17. Cost of Preparing Proposals

Costs incurred by Bidders during the preparation and subsequent submission of their proposals, and for other procurement-related activities (e.g., travel for Bidder presentations) will be the sole responsibility of the Bidders. The State will not reimburse Bidders for any such costs. No material, labor, or facilities will be furnished by the State.

2.18. Disposition of Proposals

All submitted proposals shall become a matter of public record.

2.19. Freedom of Information Act

Due regard will be given by the State of Rhode Island for the protection of proprietary information contained in all proposals received. However, Bidders should be aware that all materials associated with the selection are subject to the terms of the Freedom of Information Act and all rules, regulations, and interpretations resulting therefrom, including those from the offices of the Attorney General of the United States, Department of Health and Human Services (HHS), EOHHS, DHS, and DoA. It will not be sufficient for Bidders to merely state generally that the proposal is proprietary in nature and not, therefore, subject to release to third parties. Each and every subsection

contained within the proposal which a Bidder believes to be proprietary and/or confidential in nature must be specifically identified as such. Bidders should refer to Federal Acquisition Regulations 52.215.12 for instructions regarding identification of proposal data which they do not wish to be disclosed to the public or used by the State of Rhode Island or federal agencies except for evaluation purposes.

In addition, convincing explanation and rationale sufficient to exempt from release the specified material as contained in each subsection must accompany the proposal. The rationale and explanation must be stated in terms of the prospective harm to the competitive position of the Bidder that would result if the identified material were to be released. The Bidder will be notified prior to release of information which the Bidder has specified as proprietary. However, the final administrative authority to release or exempt any or all material so identified rests with the federal agencies and the State of Rhode Island.

2.20. Background Checks

The selected Bidder and any subcontractor shall be required to certify to the State it has obtained national criminal history background checks resulting in a satisfactory conclusion at the selected Bidder's and subcontractor's expense within ninety (90) days prior to the commencement of the contract for all respective personnel that have access to the MMIS and related systems. Further, the FA and subcontractor(s) shall provide adequate backup documentation to the State, upon request, to demonstrate support for the certification.

All site personnel shall be subject to such security clearance as the State may require.

2.21. Contract Provisions

The contract between the selected Bidder and the State of Rhode Island will include the terms and conditions contained in Section 9 of this RFP, including the State's General Conditions of Purchasing and the Information Technology (IT) Supplemental Terms and Conditions, as well as applicable appendices.

The selected Bidder shall also be expected to comply and/or sign the documents attached hereto and made a part hereof as Appendices B through H.

By its Proposal, the Bidder certifies to the State of Rhode Island that the Bidder has full power to enter into the contract and perform its obligations thereunder, that such performance would not give rise to any violation of any other contract of the Bidder, and that the person signing the Bidder's proposal has full authority and right to do so. Each Bidder will, if required by the State of Rhode Island, submit written opinion of counsel in form and substance satisfactory to the State of Rhode Island to the effect of the foregoing.

2.22. Minority Business Enterprise and Equal Employment Opportunity

Minority Business Enterprise (R.I.G.L 37.14.1)

EOHHS seeks bids in accordance with Minority Business Enterprise (R.I.G.L 37.14.1) where applicable.

For further information, visit the Website www.mbe.ri.gov. To speak with an MBE officer, call (401) 574-8253.

Equal Employment Opportunity (R.I.G.L 28-5.1)

Section 28-5.1-1 Declaration of policy – (a) Equal opportunity and affirmative action toward its achievement is the policy of all units of Rhode Island State government, including all public and quasi-public agencies, commissions, boards and authorities, and in the classified, unclassified, and non-classified services of state employment. This policy applies in all areas where the State dollar is spent, in employment, public service, grants and financial assistance, and in State licensing and regulation. For further information, contact the Rhode Island Equal Employment Opportunity Office, at (401) 222-3090.

Both requirements must be addressed in the response.

3. Description of Rhode Island Medical Assistance and Related Programs

3.1. Background

EOHHS is the single State agency responsible for Medicaid program administration. All MMIS operations are currently managed either directly or, by subcontract, through an FA contract with Hewlett-Packard Development Company, LP (HP, formerly EDS). EOHHS wishes to maintain a single contract FA relationship. EOHHS is soliciting bids for the global management of its base MMIS operations and encourages bids for several operational and technical enhancements detailed in Sections 6 and 7 of this RFP.

3.2. The Medical Assistance Program and the Global Waiver

The Rhode Island Medical Assistance Program, also known as "Medicaid" is a federal and State funded program that pays for medical and health related services for eligible Rhode Islanders.

Rhode Island operates its entire Medicaid program under a single Section 1115 demonstration project (Global Waiver) with the exception of disproportionate share hospital payments and payments to local education agencies. The State operates the Global Waiver under a five-year aggregate cap of federal funds, thereby assuming a degree of financial risk with respect to caseload and per member per month cost trends.

The Global Waiver is in effect from July 1, 2009 to December 31, 2013 and includes several distinct components:

- The Rlte Care program provides Medicaid State Plan benefits through comprehensive mandatory managed care delivery systems to most recipients under the State Plan.
- The Extended Family Planning program provides access to services to women whose income is at or below 200 percent of the federal poverty limit (FPL), and who lose Medicaid eligibility under Rlte Care at the conclusion of their 60-day postpartum period.
- Rlte Share, the State's premium assistance program, enrolls individuals who are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP) and are employees or dependents of an employee of an employer that offers a "qualified" employer-sponsored insurance.
- Rlte Smiles is Rhode Island's managed dental program for young children who have Medical Assistance coverage.
- Medical Assistance Dental Services for residents of nursing homes who have Medical Assistance coverage.

- Rhody Health Partners provides Medicaid State Plan benefits to aged, blind, and disabled beneficiaries who have no other health insurance through a managed care delivery system.
- Connect Care Choice provides Medicaid State Plan benefits to aged, blind, and disabled beneficiaries who have no other health insurance through a primary care case management system.
- The Medicare Premium Payment Program helps adults over age 65 and disabled adults pay all or some of the costs of Medicare Part A and Part B premiums, deductibles, and co-payments.
- Home and Community Based Service Programs serve individuals who need home and community based services either as an alternative to institutionalization or otherwise based on medical need. These services may be accessed through a self-directed option.

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is for all children, from birth to age 21, who have Medical Assistance coverage and are eligible to receive preventive care, routine health care, and medically necessary specialized care or services.

Under the Global Waiver, the State continues to deliver primary and acute care services through the following systems:

- **Managed Care Organizations (MCOs):** Rlte Care, Rlte Share Rhody Health Partners, and the Program of All-Inclusive Care for the Elderly (PACE).
- **Primary Care Case Management Program:** Connect Care Choice and Connect Care.
- **Pre-paid Dental Ambulatory Health Plans:** Rlte Smiles.

Current enrollment is shown in the following table:

Table 3: Current Enrollment in RI Systems

Program	7-31-2011 Enrollment
Rlte Care	123,582
Rlte Share	11,727
Rhody Health Partners	13,027
PACE	206
Connect Care Choice	2,074
Connect Care	153
Rlte Smiles	54,627

3.2.1. Medicaid Services

State Plan Services are shown in the following table. The full Medicaid State Plan is included in the Bidders' Library.

Table 4: State Plan Services

#	Service	Description
1.	Inpatient hospital services	Mandatory 1905(a)(1)
2.	Outpatient hospital services	Mandatory 1905(a)(2)
3.	Rural health clinic services	Mandatory 1905(a)(2)
4.	FQHC services	Mandatory 1905(a)(2)
5.	Laboratory and x-ray services	Mandatory 1905(a)(3)
6.	Nursing facility services for 21 and over	Mandatory 1905(a)(4)
7.	EPSDT	Mandatory 1905(a)(4)
8.	Family planning	Mandatory 1905(a)(4)
9.	Physicians' services	Mandatory 1905(a)(5)
10.	Medical and surgical services furnished by a dentist	Mandatory 1905(a)(5)
11.	Podiatrists' services	Optional 1905(a)(6)
12.	Optometrists' services	Optional 1905(a)(6)
13.	Intermittent or part-time nursing services provided by a home health agency	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
14.	Home health aide services provided by a home health agency	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
15.	Medical supplies, equipment, and appliances	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
16.	Physical therapy; occupational therapy; speech pathology; audiology provided by a home health agency	Optional 1902(a)(10)(D) 42 CFR 440.70
17.	Clinic services	Optional 1905(a)(9)
18.	Dental services	Optional 1905(a)(10)
19.	Prescribed drugs	Optional 1905(a)(12)
20.	Dentures	Optional 1905(a)(12)
21.	Prosthetic devices	Optional 1905(a)(12)
22.	Eyeglasses	Optional 1905(a)(12)
23.	Preventive services	Optional 1905(a)(13)

#	Service	Description
24.	Rehabilitative services	Optional 1905(a)(13)
25.	Services for individuals over age 65 in Inherited Medical Diseases (IMDs)	Optional 1905(a)(14)
26.	Intermediate Care Facility services	Optional 1905(a)(15)
27.	Inpatient psychiatric facility services for under 22	Optional 1905(a)(16)
28.	Nurse-midwife services	Mandatory 1905(a)(17)
29.	Hospice care	Optional 1905(a)(18)
30.	Case management services and TB-related services	Optional 1905(a)(19)
31.	Extended services for pregnant women	Optional 1902(e)(5)
32.	Certified pediatric or family nurse practitioners' services	Mandatory 1905(a)(21) is a mandatory service
33.	Nursing facility services for patients under 21	Optional 1905(a)(28) 42 CFR 440.170
34.	Personal care services in recipient's home	Optional 1905(a)(28) 42 CFR 440.170
35.	Transportation	Optional as a medical service 1905(a)(28) 440.170 required as an administrative function 42 CFR 431.53
36.	Primary care case management services	Optional 1905(a)(25)
37.	PACE services	Optional 1905(a)(26)
38.	Emergency services for certain legalized aliens and undocumented aliens	Mandatory 1903(v)(2)(A)

3.2.2. Home and Community Based Service Descriptions

Rhode Island covers the following home and community based services under the 1115 Global Waiver.

Homemaker

Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself/herself or others in the home.

Environmental Modifications (Home Accessibility Adaptations)

Those physical adaptations to the private residence and/or vehicle of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home.

Special Medical Equipment (Minor Assistive Devices)

Specialized medical equipment and supplies, including: a) devices, controls, or appliances, specified in the plan of care, which enable participants to increase their ability to perform activities of daily living; b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live.

Meals on Wheels (Home Delivered Meals)

The delivery of hot meals and shelf staples to the waiver recipient's residence.

Personal Emergency Response System

The Personal Emergency Response System (PERS) is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency.

Licensed Practical Nurse Services (Skilled Nursing)

Licensed Practical Nurse services provided under the supervision of a Registered Nurse.

Community Transition Services

Community transition services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. (Community Transition Services have not yet been implemented.)

Residential Supports

Assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in their own home and non-institutional setting.

Day Supports

Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills.

Supported Employment

Includes activities needed to sustain paid work by individuals receiving waiver services, including supervision, transportation, and training.

Supported Living Arrangements

Personal care and services, homemaker, chore, attendant care, companion services and medication oversight (to the extent permitted under State law) provided in a private home by a principal care provider who lives in the home.

Private Duty Nursing

Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law and as identified in the Individual Service Plan.

Supports for Consumer Direction

Focuses on empowering participants to define and direct their own personal assistance needs and services; guides and supports, rather than directs and manages, the participant through the service planning and delivery process.

Participant Directed Goods and Services

Habilitative or therapeutic services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan that addresses a need identified in the Individual Service Plan.

Case Management

Services that assist participants in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

Senior Companion (Adult Companion Services)

Non-medical care, supervision, and socialization provided to a functionally impaired adult.

Assisted Living

Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility.

Personal Care Assistance Services

Personal Assistance Services provide direct support in the home or community to individuals in performing tasks they are functionally unable to complete independently due to disability, based on the Individual Service and Spending Plan.

Respite

Services provided to participants unable to care for themselves that is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant.

3.2.3. Costs Not Otherwise Matchable

Costs Not Otherwise Matchable (CNOM) represent costs that cannot be funded under the Rhode Island Medicaid State Plan. Upon approval of the Rhode Island Medicaid Global Waiver, explicit authority was granted. This initiative allows the State Medicaid Agency to claim specific health-related services for matching federal funds.

The purpose of including CNOM in the Global Compact Waiver is to demonstrate that the provision of Medicaid funded services to non-Medicaid eligible persons can delay and/or prevent the need for full Medicaid eligibility.

The CNOM eligibility groups are as follows:

- Children and families in managed care enrolled Rite Care.
- Medicaid parents who have behavioral health conditions that result in their children being placed in temporary State custody.
- Children with special health care needs who are 21 and under who would otherwise be placed in voluntary State custody-residential diversion
- Elders at risk of long-term care (LTC).
- Adults with disabilities at risk for LTC who would otherwise not be eligible for Medicaid.
- Uninsured adults with mental illness.
- Children at risk for Medicaid and/or institutional care.
- HIV-positive individuals who are otherwise not eligible for Medicaid.
- Services billed to the Rhode Island Department of Health by the federally qualified health centers (FQHC) providing a limited benefit package for uninsured individuals.

The following State Agencies manage programs that have been identified as CNOM eligible:

- EOHHS;
- DCYF;
- DHS, including DEA;
- DOH; and
- BHDDH.

3.3. Organization of EOHHS and Related Departments

This section includes a description of the organization of EOHHS and other departments and agencies that administer programs included in the Rhode Island Medical Assistance Programs.

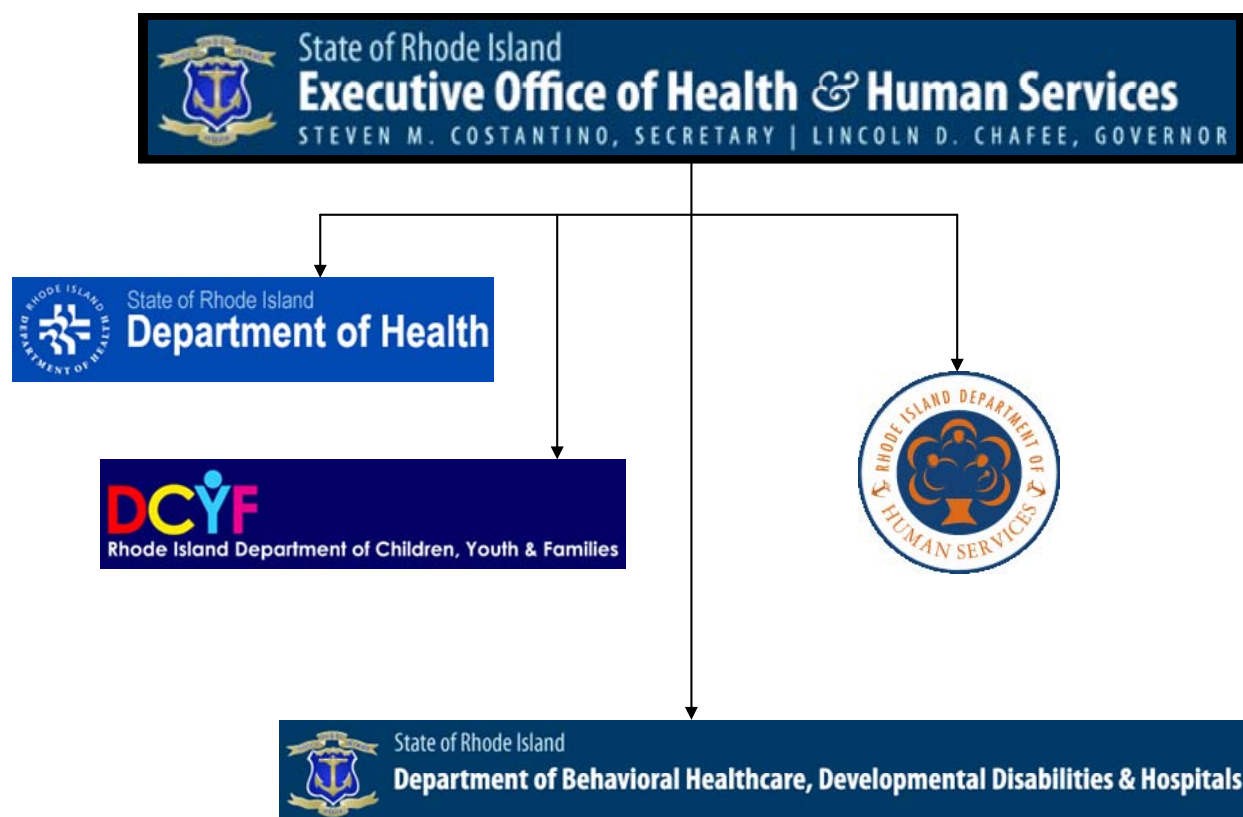


Figure 1: Organization of EOHHS and Related Departments

3.3.1. Executive Office of Health and Human Services

EOHHS administers Rhode Island's health and social service programs. EOHHS is the single State agency duly authorized by CMS to administer the Medicaid program for the State of Rhode Island. EOHHS is authorized to work with the other health and human services departments to delegate specific elements of the administration of the Medicaid program.

EOHHS is responsible for the MMIS FA contract and oversight of day-to-day MMIS operations.

3.3.2. Department of Human Services

DHS offers a full continuum of services for families, adults, children, elders, individuals with disabilities, and veterans, including the Supplemental Nutrition Assistance Program, RI Works (Temporary Assistance for Needy Families), and Child Care Support Enforcement. DHS also determines eligibility for Medical Assistance Programs and provides some case management for long-term care Medicaid eligibles.

The DHS' DEA operates Adult Day Care services through several community-based agencies for elderly beneficiaries in their care. DEA operates the Meal on Wheels program and also provides limited case management. DEA provides State-funded-only homecare benefits to eligible elderly beneficiaries. DEA operates the Rhode Island Pharmaceutical Assistance Program (RIPAE), which provides co-pays for certain drug formularies. DEA also co-manages the "elderly" waiver with EOHHS.

DEA utilizes the MMIS to process Adult Day Care and homecare claims and for prior service authorization of these services. DEA makes use of the MMIS eligibility system for Medicaid-eligible beneficiary verification and for provider enrollment. The MMIS processes RIPAE pharmacy Point of Service (POS) claims.

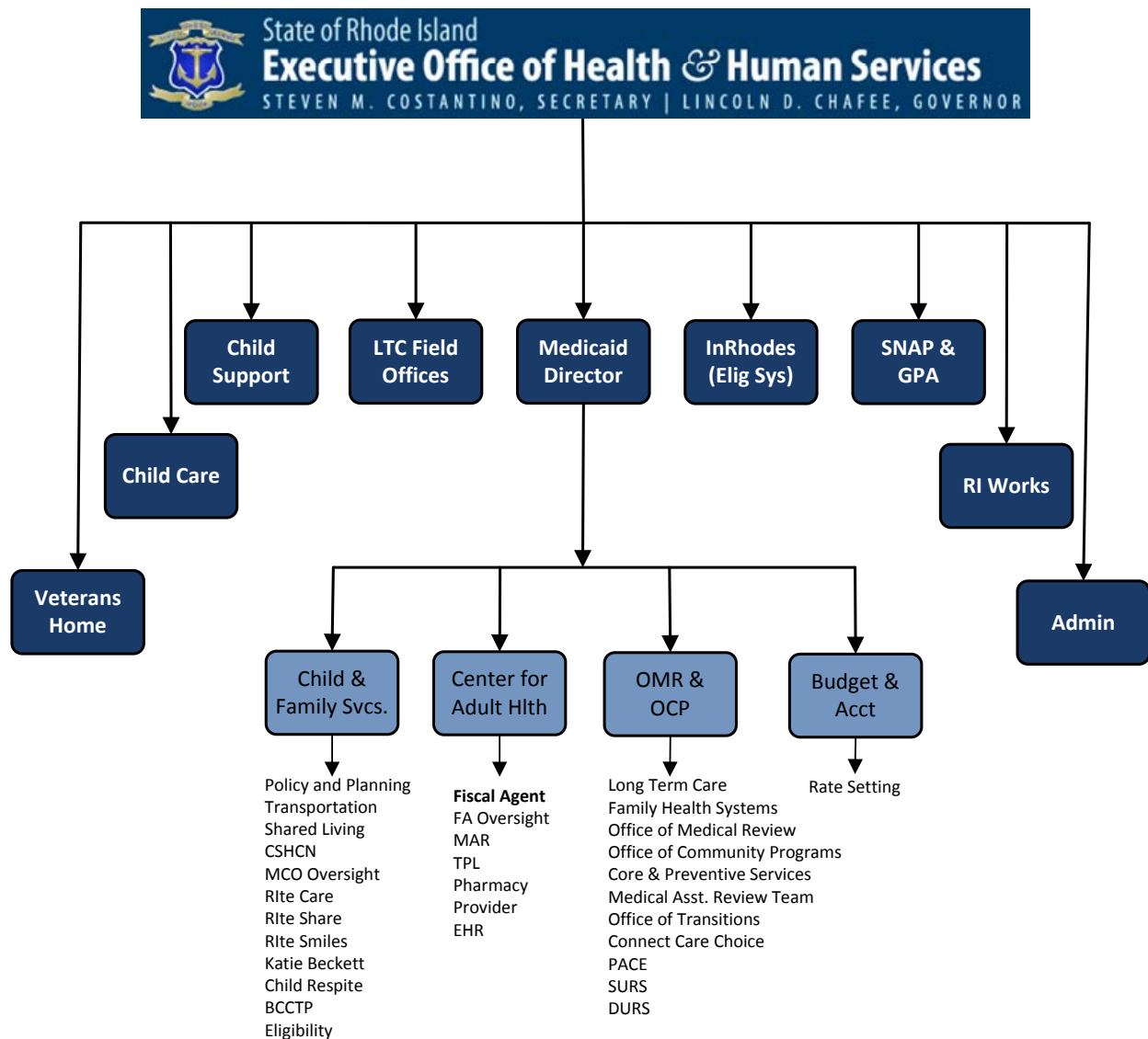


Figure 2: Organization of the EOHHS

3.3.3. Department of Children, Youth & Families

DCYF is responsible for providing institution and community-based services for children in their care. DCYF manages several group homes and provides various levels of case management and direct and contracted mental health services. DCYF processes vendor payments through the Rhode Island Children's Information System (RICHIST), their statewide automated child welfare information system for case management and tracking, with payments processed through the State's Integrated Financial Management System (RI-FANS).

DCYF sends claims and prior authorizations to the MMIS for Medicaid eligible processing and queries the database for eligibility verification and provider enrollment.

3.3.4. Department of Health

DOH manages the Women's Cancer Screening Program and refers qualified eligibles to the EOHHS for the Breast and Cervical Cancer Treatment Program. DOH uses the MMIS primarily as the conduit for their providers, who bill the MMIS directly.

3.3.5. Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

BHDDH is the State authority for mental health, substance abuse, and developmental disabilities. BHDDH manages inpatient hospital services provided by Eleanor Slater Hospital and Intermediate Care Facility for the Mentally Retarded services provided in satellite group homes. It also manages the Community and Living Supports program, which provides services to beneficiaries with developmental disabilities. BHDDH is responsible for Rehabilitation Services and many of the CNOM programs.

3.3.6. Department of Administration; Office of Accounts & Control

The Office of Accounts & Control (A&C) is located in downtown Providence, RI and maintains access to State account spending and payment and billing of State expenditures. FA staff interacts with A&C staff for confirmation and verification of MMIS cycle payment file transfers where required. The State Controller at A&C is a vital part of MMIS communications and payment cycle processing because of the size of Medicaid program expenditures.

3.4. MITA SS-A

CMS introduced MITA as an initiative to help states improve the operation of their Medicaid programs. As part of the initiative, CMS developed the MITA Framework, currently in Version 2.0. A MITA SS-A based on the MITA Framework is now a prerequisite for federal funding of Medicaid program enhancements. MITA prescribes an enterprise architecture for Medicaid programs that is comprised of three architectural layers:

- Business Architecture – a layer that focuses on business processes and a maturity model that describes in detail how Medicaid operations are expected to mature over time.
- Information Architecture – a layer that focuses on data and information to support the business architecture, including data management strategies and data standards.
- Technical Architecture – a layer that focuses on the technology that supports both the information architecture and business capabilities, and

defines a set of services and standards that States can use to plan and specify their future systems.

MITA provides a standardized frame that facilitates Rhode Island's upcoming system improvements and implementations with enhanced CMS funding. More than a "compliance" activity, MITA facilitates transformation of business processes, required data and information, and supportive technology of the Medicaid organization. These transformations are consistent with converging Rhode Island, federal, and industry-wide influences. MITA directly impacts Rhode Island's ability to improve outcomes, contain costs, and reduce administrative burdens.

The MITA Framework broadens the definition of the MMIS. For example, in addition to core provider, claims, and eligibility processes, the MITA SS-A requires evaluation of "administrative" tasks such as vendor contracting, program integrity, care management, and policy-making. The MITA SS-A guidance includes 78 generic Medicaid business processes, organized by business area, to which Rhode Island mapped its business processes.

Rhode Island completed the MITA SS-A in June of 2011. Results of the MITA SS-A were used to create the functional requirements for the transition and enhancement of the MMIS. Relevant sections of the MITA SS-A can be found in the Bidders' Library.

3.5. MMIS Background

The current Rhode Island MMIS was brought online in December 1993. It is a rules-based, table-driven client server paradigm that supports integrated modular MMIS functionalities and robust data management capabilities. The Rhode Island MMIS was adapted from the Vermont AIM system to meet Rhode Island-specific healthcare claims processing and policy standards. It has since evolved to include many State-specific healthcare claim reimbursement and reporting processes.

The current federally certified Rhode Island MMIS supports the healthcare claims processing and administration of more than 190,000 Rhode Islanders who utilize some \$2 billion Rhode Island Medical Assistance program dollars. EOHHS requires a dynamic MMIS and sound FA vendor relationship to support these healthcare delivery efforts.

The core (AIM) system is currently hosted by HP at their Herndon, VA Data Center facility. The main MMIS is made up of over 13,000 individual modules, all of which are maintained with a separate version number.

It is anticipated that the Successful Bidder will transfer operations to its own facility, which must be approved by the State. Any hardware, software, and communications interfaces owned by the State will be transferred to the Successful Bidder. Additional information regarding these assets can be found in the Bidders' Library.

The MMIS system interfaces with a number of external systems, including other Rhode Island agency systems, federal government systems, and commercial service provider systems. Two key interfaces within the State of Rhode Island network are the InRhodes eligibility system and the EOHHS Data Warehouse. The EOHHS Data Warehouse is also hosted at the HP facility and is considered part of the MMIS.

Figure 3 illustrates the core data systems and the data relationships between internal and external applications.

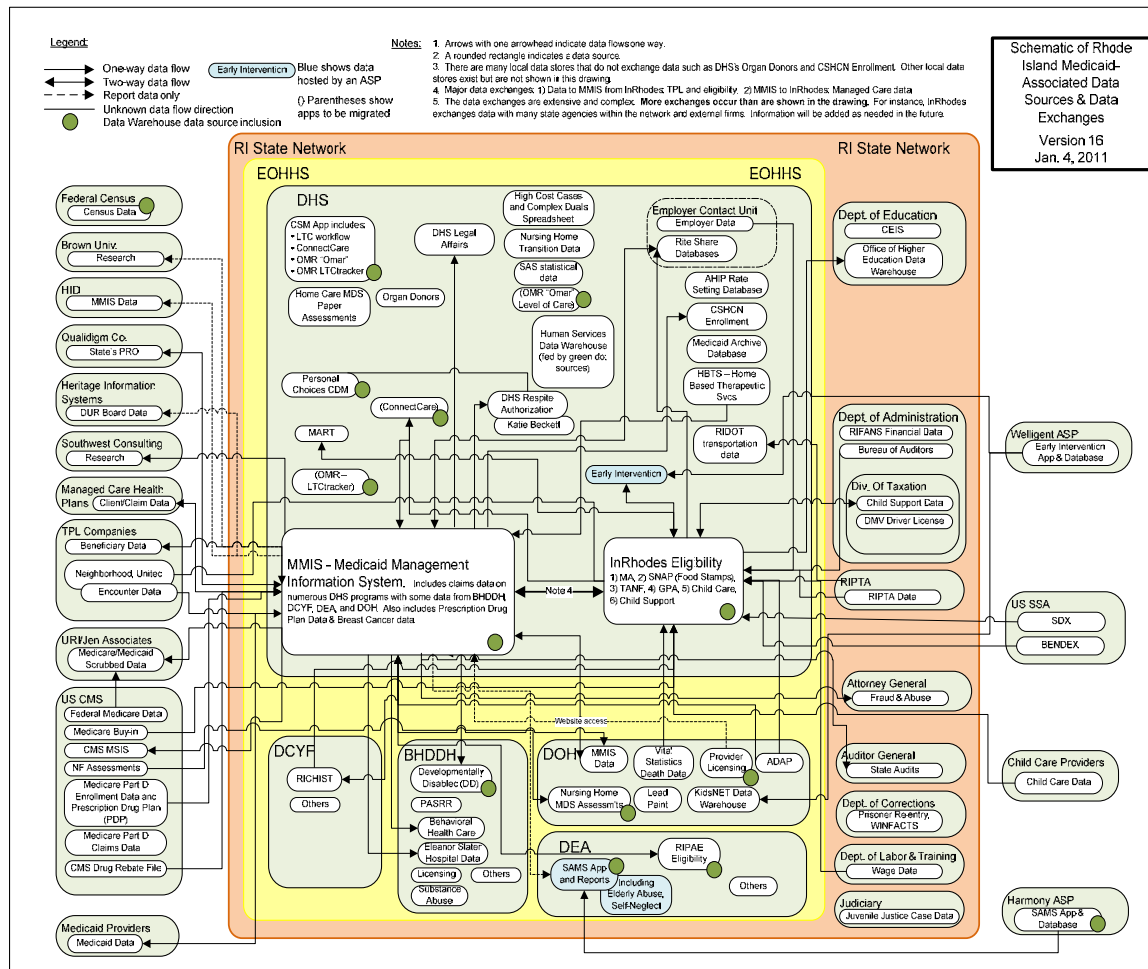


Figure 3: Medicaid Data Flow

The diagram below provides a high-level view of the system architecture and network connectivity.

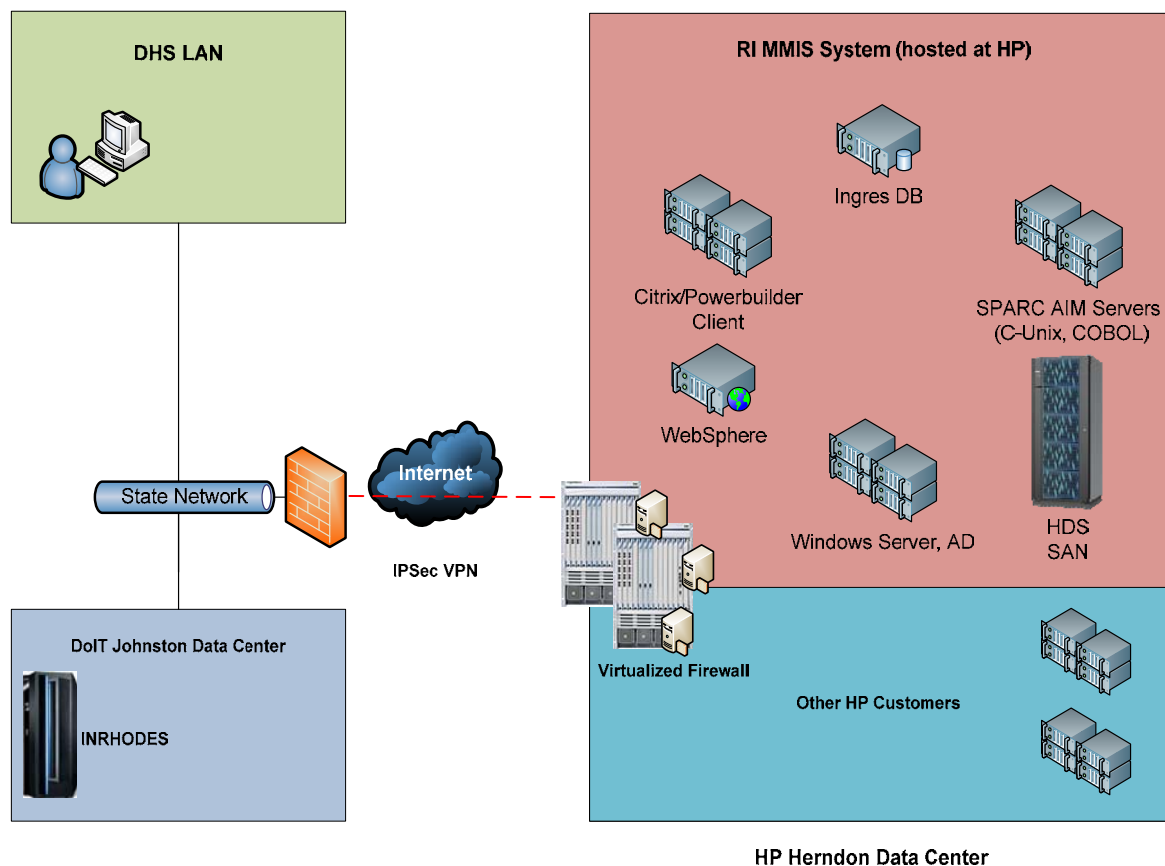


Figure 4: MMIS High Level Architecture

The MMIS application is comprised of the following subsystems or application modules:

- Claims Processing – Provides claims inventory control; performs claims entry, edits, audits, and correction control; and performs claims pricing assessments and history data.
- Provider Services – Updates and maintains provider data store; produces provider reports allows online access to provider data; and monitors new provider enrollment and annual provider re-certification.
- Recipient Services – Captures and maintains recipient data store by receiving information from various sources within and outside the Rhode Island system; and allows recipient data inquiries and updates.
- Financial – Processes claim adjustments and financial transactions; maintains drug rebate processing; and produces payments for providers.
- Reference – Updates and maintains reference data store and edits/audits rules; allows online access to reference data; and produces reference reports.

- Third Party Liability (TPL) – Updates and maintains TPL data stores via online screens; allows online access to TPL data; edits claims for cost avoidance; and recovers funds from third-parties when TPL resources are identified after Medical Assistance has paid a claim.
- Management and Administration Reporting (MAR) – Generates MARS Reports, as well as financial and budget reports.
- Surveillance and Utilization Review (SUR) – Updates the SURS Control Files; extracts paid claims data; and processes quarterly reports.
- Managed Care – Collection, verification, and storage of the provider files, client files, encounter files, and aggregate files.
- All of these subsystems and application modes interface with other subsystems in the MMIS to receive or provide needed data.

3.5.1. Host Platform

The core MMIS system is hosted on Sun SPARC servers running Solaris 10. Support subsystems such as Microsoft Active Directory are hosted on Dell and HP Intel-based servers and utilize Windows Server 2003 and 2008. HP is using VMWare for virtual hosting. The SPARC servers are connected to a Hitachi Data Systems SAN storage solution. There is little or no redundancy built into the host environment for the MMIS.

Backups are conducted using a StorageTek SL500 Tape Library and Veritas backup software. Servers are connected via fiber channel to the storage and backup environment.

3.5.2. Application

The HP AIM system is the core MMIS application. AIM is developed 60 percent in UNIX C code and 40 percent in COBOL running on Sun Solaris 10 platform. UNIX Job scheduling is accomplished using Autosys and individual UNIX scripts. Client access to AIM is provided via a Power Builder application running on a Citrix Presentation Server to allow thin client access from Rhode Island. Web application services are developed in IBM WebSphere and data is stored in an Ingres data base system. HP has migrated the data to an Oracle RDBMS system to support greater interoperability and supportability of the MMIS data.

3.5.3. MMIS Application Development

The Rhode Island Development Environment exists on a UNIX server separate from the main MMIS Production Server. This server is noted as “RIDEV” on the network topology. It is configured to look exactly like the production server and contains three (3) separate test environments. All of the supporting software versions (DBMS, compilers, job scheduler, etc) match the version running in production unless the specific project being worked on includes upgrades to one or more of these components. A description of each of these development environments are as follows:

- Test – This environment is used primarily for unit testing by the developers. Necessary data is entered by the developers.
- Model Office – This environment contains production “like” data and is used as the primary test environment by the business analyst for testing. The majority of the test results reviewed with the client during testing walk through is produced from this environment. Rigid standards exist to maintain the integrity of the environment.
- User Acceptance Testing (UAT) – This environment contains data that is refreshed from the production environment on a periodic basis. It is used as necessary to perform final testing and is intended to be the environment that the client would use to do end user testing. It is very seldom used in this way.

In addition to the three standard environments described above, separate development environments are set up to support projects as necessary. This often happens when a large-scale project is being worked over a long period of time (e.g., HIPAA, Data Base Replacement, etc.) and normal modifications need to be made to the MMIS.

3.5.4. Network

EOHHS connects to the MMIS in Herndon via a 30 MB Internet connection and IPsec Virtual Provider Network (VPN). The Herndon data center core network is comprised of a pair of Cisco 6509 switches with HP Procurve access layer switches.

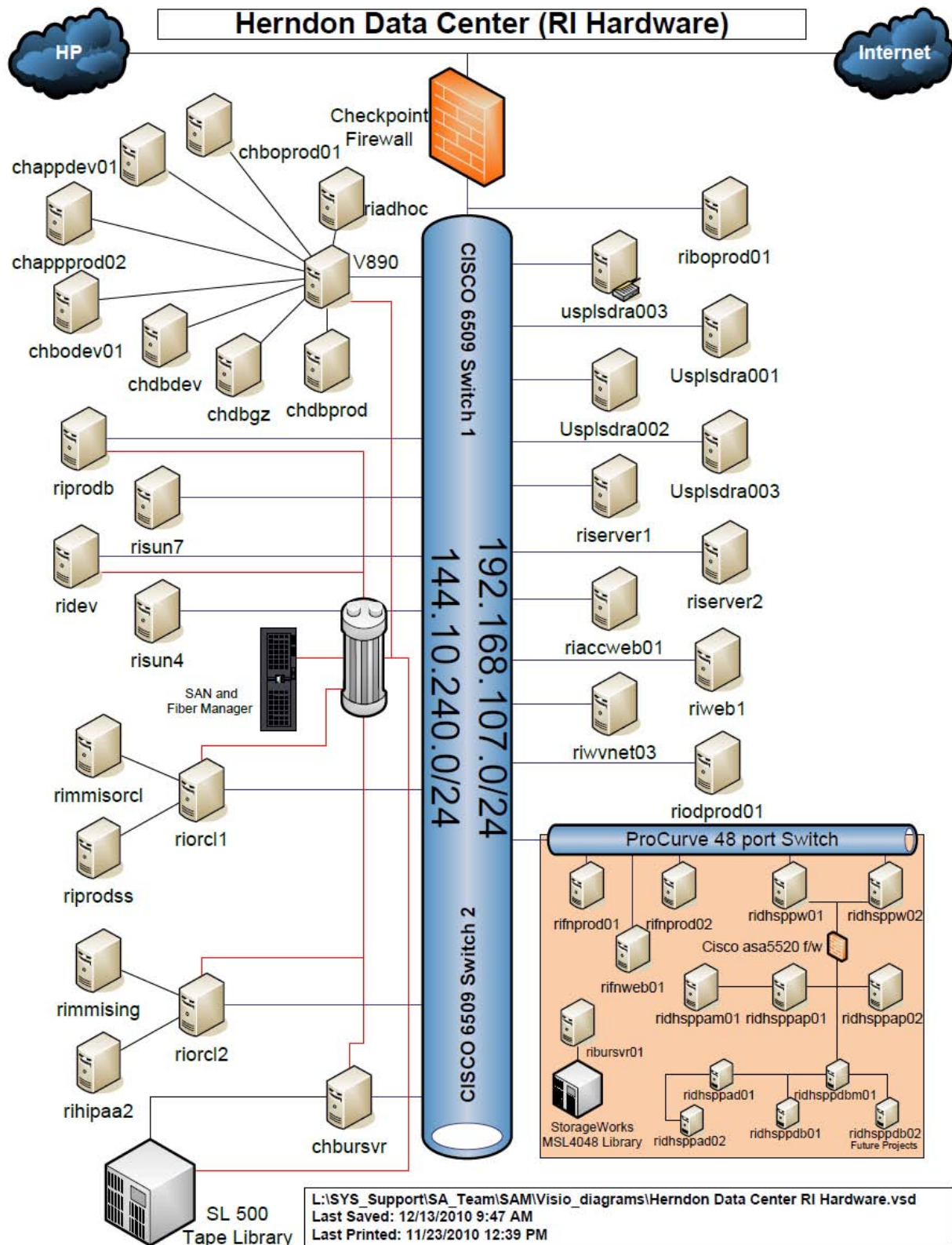


Figure 5: Herndon Network View

3.5.5. Security

Perimeter security and VPN termination are provided at the Herndon Data Center using a Checkpoint Firewall implementation on Crossbeam hardware. A virtual firewall instance is dedicated to the Rhode Island MMIS systems. Internal network segmentation is provided by a Cisco ASA 5520 firewall.

Client authentication security is provided by Microsoft Active Directory through the Windows Server/Citrix thin client environment.

Ingres database access is controlled via a UNIX account and password combination.

3.5.6. Interfaces/Subsystems

The following table shows primary MMIS interfaces.

Table 5: MMIS Interfaces

#	Responsible Party	Interface Business Purpose	Source
1	Qualidigm	Daily Prior Authorization (PA) Files	
2	EOHHS	Data warehouse feed	Human Services DW
3	EOHHS/FA	POS –BUSPASS/Pharmacies	POS
4	EOHHS/FA	MARS/SURS Reporting	
5	EOHHS/FA	CMS SUBS	
6	EOHHS/FA	Drug Rebate Processing	
7	EOHHS/FA	Financial Processing	
8	EOHHS/FA	Web-based claims	REVS/Translator
9	EOHHS/FA	Medicare ID Cards	
10	EOHHS/FA	Medicare Intermediaries	
11	EOHHS/FA	Providers	
12	EOHHS/NGIS/DoIT	Eligibility	InRhodes
13	EOHHS/FA	DUR	First Data/HCFCA

3.6. EOHHS Data Warehouse (CHOICES)

The data warehouse solution is a newly implemented system designed to aggregate all Medicaid data repositories into a single location for reporting, data mining, and data analysis. The EOHHS Data Warehouse utilizes an Extract, Transform, Load (ETL) tool for scrubbing inbound data streams (Informatica). The multiple data sources that house Medicaid based data do not follow a standard schema or format, requiring extensive mapping efforts to “scrub” and “de-duplicate” the data for storage in the data marts.

3.6.1. Data Feeds

The current deployment has been loaded with a significant amount of data from some of the major repositories of MMIS and claims-based data. Figure 6 illustrates the major sources of data and source systems available in the data warehouse.

Data Warehouse consolidated subject areas

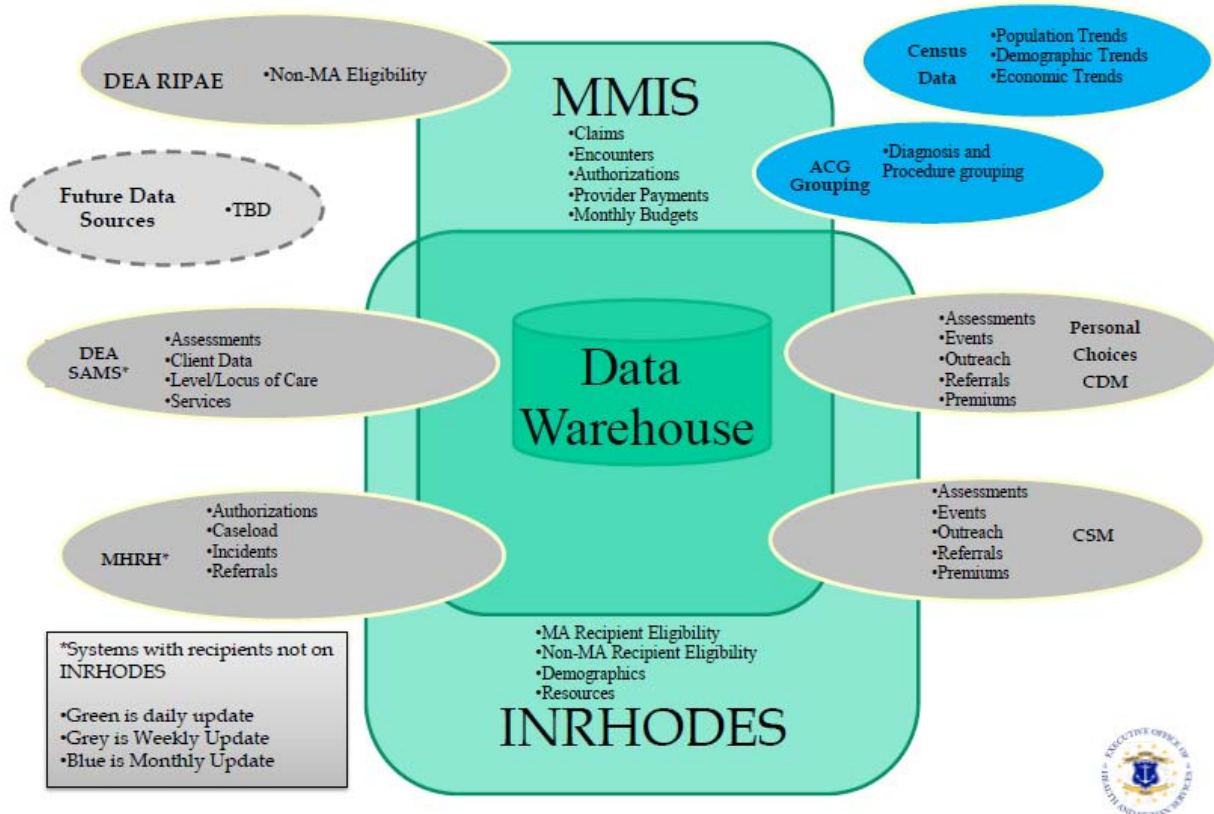


Figure 6: EOHHS Data Warehouse Data Mapping (Logical)

Error! Not a valid bookmark self-reference. details the data currency and refresh cycle of these data feeds. All updates are being processed through batch processing and ETL loads of new data based on the schedule defined in.

Table 6: EOHHS Data Warehouse Data Sources

Data Source Name	Initial Date Range Loaded	Refresh or Update Cycle
InRHODES	July 1, 2004 to present	Updated in daily batches but may be delayed at month-end.
MMIS	July 1, 2004 to present	Updated daily with one day lag.
BHDDH - DD	All available	Refreshed weekly with complete overlay of data.
DEA SAMS	All available	Refreshed weekly with complete overlay of data.
Personal Choices	All available	Refreshed weekly with complete overlay of data.
DEA RIPAE	All available	Refreshed weekly with complete overlay of data.
Census Data	Currently Rhode Island city population projections 2000-2030	As needed. More census data can be added as need arises.
CSM	Not available yet, reporting data will be loaded when available	Plan is for weekly refresh.
DOH Minimum Data Set (MDS) Nursing Home Assessment Data	All available	Refreshed weekly with complete overlay of data.

3.6.2. Physical Location

The EOHHS Data Warehouse is hosted by HP Enterprise Services at the Herndon, VA data center (same location as the MMIS). The details regarding the platform and physical hosts are included in the Bidders' Library.

3.6.3. Application

The application is a standard three-tier deployment with a Web-based front end using the Business Objects Web client. The application tier is comprised of the core Business Objects Enterprise, WebSphere, and multiple job processing servlets. The backend database leverages Oracle 11g.

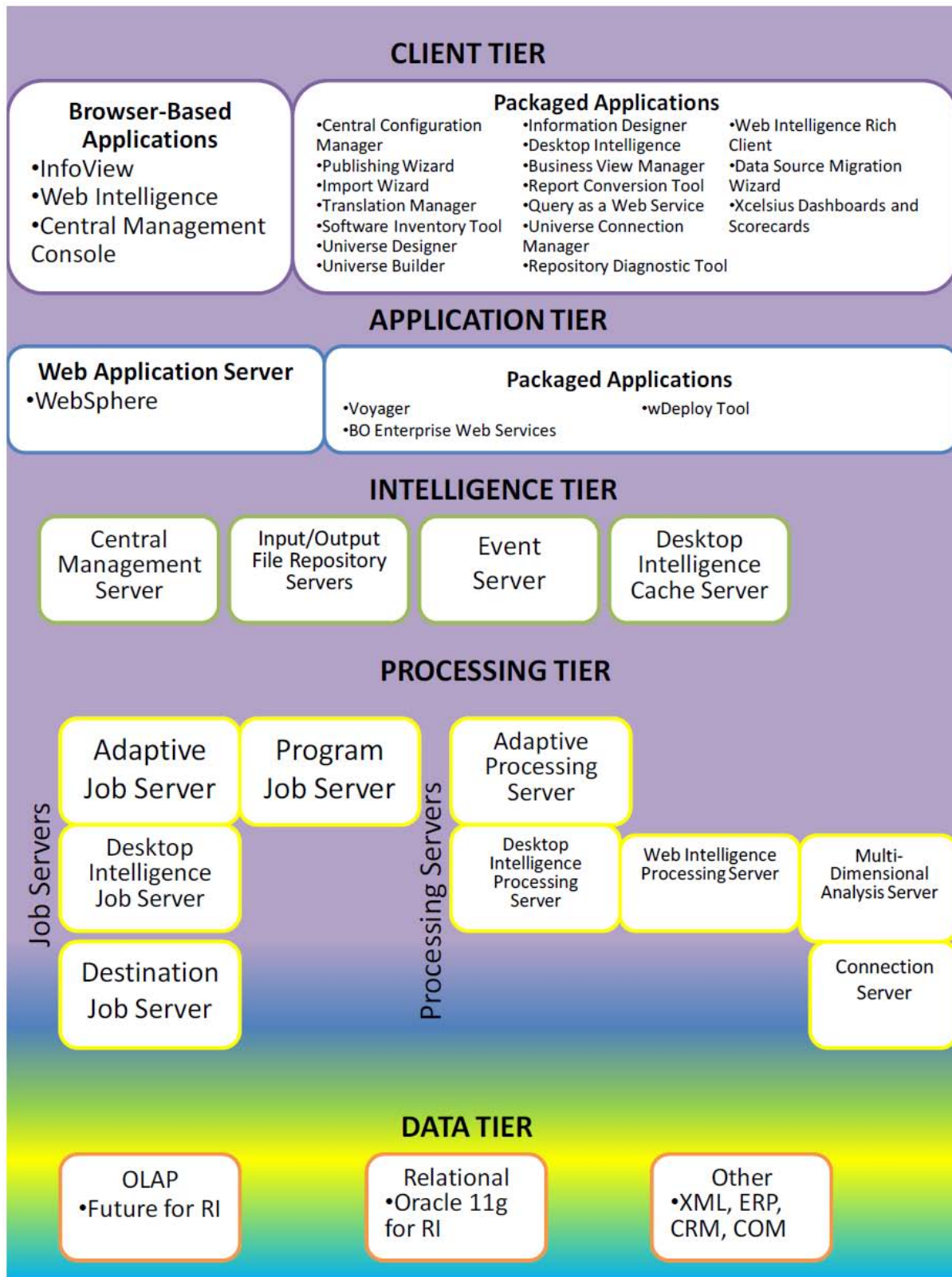


Figure 7: EOHHS Data Warehouse Design (Logical)

3.6.4. Network

The network topology is the same as the MMIS as they are hosted within the same network at the Herndon HP Data Center, depicted in Figure 5.

3.6.5. Security

The Business Objects model relies extensively on role-based access control to ensure that users only have access to the data that they have been authorized. The access control model in place uses the roles in Table 7 to delineate access to certain fields (ePHI) in the data marts. The EOHHS Data Warehouse is not currently accessible external to the State network and does not now support external users. Therefore, security testing has not been performed on the Data Warehouse.

Table 7: EOHHS Data Warehouse User Roles

Data Warehouse User Role	Non-PHI field such as Claim Amount	PHI field such as SSN	Substance Abuse Data Rows	Mental Illness Data Rows	HIV Data Rows
Standard PHI User Role	Viewable	Viewable	Not Viewable (Invisible to user)	Not Viewable	Not Viewable
Substance Abuse User Role	Viewable	Viewable	Viewable	Not Viewable	Not Viewable
Mental Illness User Role	Viewable	Viewable	Not Viewable	Viewable	Not Viewable
HIV User Role	Viewable	Viewable	Not Viewable	Not Viewable	Viewable
Non-PHI User Role	Viewable	Not Viewable	Not Viewable	Not Viewable	Not Viewable

3.6.6. Interfaces

Table 8: EOHHS Data Warehouse Interfaces

#	Responsible Agency	Interface Business Purpose	Data Type
1	DHS's DEA Division	DEA RIPAE	Non – MA Eligibility
2	DHS's DEA Division	DEA Harmony for Aging and Adult Services (SAMS) Case Management	Assessments Client Data Level of Care Level of Service
3	BHDDH	BDDH	Authorizations Caseload

#	Responsible Agency	Interface Business Purpose	Data Type
			Incidents Referrals
4	EOHHS/FA	Census Data	Population trends Demographic Trends Economic trends
5	EOHHS	ACG Grouping	Diagnosis and Procedure grouping
6	EOHHS	CSM	Assessment Events Outreach Referrals Premiums
7	EOHHS	Personal Choices CDM	Assessment Events Outreach Referrals Premiums
8	EOHHS/FA	MMIS	Claims Encounters Authorizations Provider Payments Monthly Budgets
9	DHS/DoIT	InRhodes	MA Recipient eligibility Non-MA eligibility Demographics Resources
10	DOH	MDS	Nursing Home Assessment data

3.7. EOHHS Enterprise Application Architecture Strategy

EOHHS has an Enterprise Application Architecture Strategy for the long-term improvement of its enterprise systems and technical capabilities. This strategy is part of the Enhanced MMIS Transition strategy and is aligned with the:

- MITA Technical Architecture goals;
- CMS Enhanced Funding Requirements: Seven Conditions and Standards; and
- EOHHS Strategic Technology Plan.

EOHHS intends to implement this strategy over time, through a series of technical infrastructure enhancements and new system implementations. This strategy has two central tenets:

- EOHHS needs an enterprise scale hardware and software infrastructure on which it can implement new systems. EOHHS can then leverage this new infrastructure when acquiring and implementing new applications and systems.
- EOHHS can better manage the transformation in smaller incremental phases. A phased approach allows limited State resources to focus on the most important strategic and legislation-driven changes first, and then address less critical system replacements or enhancements in the long-term. This incremental approach improves the probability of success in each phase and reduces overall risk by increasing the number of decision points in the process, thus providing the ability to apply lessons learned in each phase to subsequent phases

Further information on the EOHHS' IT architecture strategy can be found in the Bidders' Library.

4. Proposal Submission Requirements

This section includes instructions for submission of Technical and Cost proposals. All proposals that are not presented and submitted in accordance with the requirements below may be rejected.

4.1. General Instructions

4.1.1. Bidder Registration and General Compliance Requirements

Bidders wishing to bid on this MMIS RFP must be registered with the Rhode Island DoA, Office of Purchases Rhode Island Bidder Information program (RIVIP). Registration can be accomplished online at <http://www.purchasing.ri.gov>.

Bidders wishing to bid on this MMIS RFP must complete and include a signed W-9 Request for Taxpayer Identification Number and Certification in the Technical Proposal with their Proposal, as specified in Section 4.2.4 of this RFP. A downloadable W-9 can be accessed at <http://www.purchasing.ri.gov/rivip/publicdocuments/fw9.pdf>.

Bidders must have at least one representative at the mandatory Pre-Proposal Conference as described in Section 2.6 of this RFP.

Bidders must submit a Letter of Intent to submit a proposal as described in Section 2.7 of this RFP.

Bidders must comply with the following:

- All applicable terms defined in R.I.G.L. 37-2, which can be accessed at <http://www.rilin.state.ri.us/Statutes/TITLE37/37-2/INDEX.HTM>
- Applicable Office of Purchases Rules, Regulations & General Conditions of Purchases as detailed at <http://www.purchasing.ri.gov/rivip/TabCont.asp>
- Terms detailed in Appendix A - General Terms and Conditions for State Contracts at <http://www.purchasing.ri.gov/rivip/publicdocuments/gencond.pdf> and in Appendix A to this RFP

4.1.2. Bidder Proposals

Bidders' proposals must include the components detailed in Sections 4.2 through 4.3 of this RFP.

Bidders must submit a complete bid that addresses all requirements in Sections 5: Statement of Work, Section 6: Functional Requirements, and Section 7: Technical Requirements of this RFP. No partial bids will be accepted. Any bids submitted that are deemed to be incomplete may be rejected by the State.

Bidders must submit proposals in two separate parts: 1) a Technical Proposal and 2) a Cost Proposal. The cover page of each proposal document must

include the name and address of the Bidder, the date of submission, the title "Proposal for the Transition, Enhancement, Operation, and Maintenance of the Medicaid Management Information System," and the signature and title of the appropriate officer authorizing the proposal. The Technical Proposal and the Cost Proposal must be organized in the exact order listed in Sections 4.2 and 4.3 of this RFP.

All bids must be sealed and must be addressed to:

Mr. Jerome Moynihan, C.P.M., CPPO
Administrator, Purchasing Systems
Division of Purchases (2nd FL), Department of Administration
One Capitol Hill
Providence, Rhode Island 02908
Telephone: (401) 574-8119

Proposals must be submitted in a single box or envelope (or boxes/envelopes labeled 1 of 3, 2 of 3, 3 of 3, etc.) clearly marked "SEALED BID" and show the title, "Proposal for the Transition, Enhancement, Operation, and Maintenance of the Medicaid Management Information System" and include the proposal due date and the name of the Bidder.

The following proposal delivery methods are acceptable:

- U.S. Mail: Bidders are cautioned that it is their responsibility to mail proposals in sufficient time to ensure receipt by the State prior to the proposal due date and time.
- Express Delivery: If bids are being sent via an express delivery service, Bidders are responsible for clearly designating the proposal delivery contact and address, including telephone number, on the outside of the delivery envelope or box.
- Hand Delivery: Hand-carried bids shall be delivered to Mr. Jerome Moynihan at the address above prior to the proposal due date and time.

The State will not accept Bidder Proposals submitted by electronic e-mail or fax.

Technical Proposals and Cost Proposals must be sealed in separate envelopes or boxes within the "Sealed Bid." Each Proposal shall be clearly marked "Technical Proposal" or "Cost Proposal" and include the title, proposal due date, and name of the Bidder.

Bidders may include material not specifically requested by the State that provides relevant information to support their response. Since additional materials submitted will not be scored and will have no bearing on final selection, Bidders should consider limiting the amount of extra material they submit with their responses. There is no guarantee that evaluators will review such materials.

Each proposal response section should provide a cross-reference to the pertinent section in the RFP. When material is pertinent to multiple requirements, multiple cross-references are allowed.

4.2. Technical Proposal Requirements

This section includes requirements for submission of Technical Proposals in response to this RFP. Bidders must submit five (5) hard copies of the Technical Proposal, each in a three-ring binder, and ten (10) CD-ROM copies in Microsoft Office (Word, Excel, and PowerPoint) 2003 format or Adobe Acrobat Portable Document Format (PDF). One hard copy of the Technical Proposal must contain original signatures and be clearly marked as the "Original Technical Proposal."

Bidders must submit Technical Proposals in the order specified and number the sections of their response using the following section numbers:

1. RIVIP Bidder Certification Cover Form
2. Transmittal Letter
3. Mandatory Technical Proposal Requirements Checklist
4. Notices and Certifications
5. Executive Summary
6. Bidder Identification Information including Subcontractor Identification
7. Bidder Financial Information
8. Bidder Qualifications and Experience
9. Approach to Completing the Statement of Work (SOW)
10. Approach to Project Staffing
11. Approach to Meeting Functional and Technical Requirements

Proposals must be printed on 8½ X 11 inch paper (letter size) and double sided. Proposals shall be single-spaced and the text font must be no smaller than 12 points. Tables and figures may be in smaller font but must be legible.

4.2.1. RIVIP Bidder Certification Cover Form (Section 1)

A signed copy of the RIVIP Bidder Certification Cover Form must be submitted with the Technical Proposal. Bidders may download the form at <http://www.purchasing.ri.gov/rivip/Standard.asp>.

4.2.2. Transmittal Letter (Section 2)

Bidders must submit a Transmittal Letter written on the Bidder's official business stationary and signed by an official authorized to legally bind the Bidder. The Transmittal Letter must include the following statements:

- An unequivocal statement which acknowledges and agrees to all of the rights of the State of Rhode Island, including the procurement rules and procedures, terms and conditions, and all other rights and terms specified in this RFP.

- A statement of the Bidder's willingness to enter into an agreement with the State, which includes a reference to the terms and conditions presented in Section 9 of this RFP;
- An affirmative statement agreeing to the payment and retainage terms stated in Section 9.2.20 of this RFP;
- The Bidder's Federal Tax Identification Number;
- Confirmation that the Bidder is licensed to do business in the State of Rhode Island;
- A statement that the person signing this proposal is authorized to make decisions as to the proposed work and that he or she has not participated, and will not participate, in any action contrary to the RFP;
- The name and telephone number of the Bidder's representative who may be contacted for all contractual matters;
- A statement that the proposal was developed without collusion with other eligible Bidders;
- A statement that the Bidder does not and will not have any interest that will conflict, in any manner or degree with the performance of services required under this RFP;
- The Bidder's assurance that the proposal will remain in full force and effect for at least 180 days from the proposal due date, which will be specified in the Transmittal Letter ;
- A statement confirming that no cost information is included in the Technical Proposal;
- A statement from the Bidder verifying that the applicable software applications for this project meet the DoA, Division of Information Technology's "Acceptable Use Policy" as documented in the Bidders' Library;
- If the use of subcontractor(s) is proposed, a statement from the Bidder that it will use the proposed subcontractors services; and each subcontractor shall be appended to the Transmittal Letter and signed by an individual authorized to legally bind the subcontractor stating:
 - o The scope and percentage of work to be performed by the subcontractor (measured as a percentage of the total agreement price paid directly to the subcontractor);
 - o The subcontractor's willingness to perform the work indicated; and
 - o The subcontractor's intent to sign a formal agreement with the Bidder if the Bidder is awarded the Contract; and
- A statement that neither the Bidder nor any proposed subcontractor has been found in default of previous contracts in the State of Rhode Island.

4.2.3. Mandatory Technical Proposal Submission Requirements Checklist (Section 3)

Bidders must complete and submit a Mandatory Technical Proposal Submission Requirements Checklist. All copies must be signed, and the copy with the original signature must be included in the “Original Technical Proposal.”

The template for the Mandatory Technical Proposal Submission Requirements Checklist is included in Appendix M.1 to this RFP.

4.2.4. Notices and Certifications (Section 4)

Vendors must complete and include a signed copy of the following forms:

- The Independent Contractor Certification, as required by R.I.G.L. 28-29-17.1 (Section 4.1). A downloadable version can be accessed at http://www.dlt.ri.gov/wc/pdfs/forms/employer/DWC_11_IC_Mar06.pdf;
- Drug Free Work Place Policy Contractor Certificate of Compliance and Subcontractor Compliance (If applicable) (Section 4.2), which may be found in Appendix D to this RFP;
- Certification Regarding Environmental Tobacco Smoke (Section 4.3), which may be found in Appendix F to this RFP;
- Certification Regarding Debarment, Suspension, and Other Responsibility Matters – Primary Covered Transactions (Section 4.4), which may be found in Appendix G to this RFP; and
- A signed W-9 Request for Taxpayer Identification Number and Certification in the Technical Proposal (Section 4.5). A downloadable W-9 can be accessed at <http://www.purchasing.ri.gov/rivip/publicdocuments/fw9.pdf>, and a copy is provided in Appendix H to this RFP.

4.2.5. Executive Summary (Section 5)

Bidders’ Technical Proposals must include an Executive Summary of not more than ten (10) pages. The Executive Summary should summarize and highlight relevant contents of the Proposal to provide the State administrators and the Evaluation Committee with a broad understanding of the Bidder’s Technical Proposal.

Bidders should summarize how their proposal meets the requirements of this RFP and why the Bidder is best qualified to perform the work required.

The proposal shall include a summary of the following:

- The Bidder’s understanding of the project, project management approach, and commitment to successfully performing all project activities;
- The Bidder’s proposed approach to:

- o Transition of the current Rhode Island MMIS, related systems, and FA operations
- o Design, testing, and implementation of enhancements; and
- o Ongoing operations and maintenance of the MMIS and related system;
- Project challenges and risks, and suggested mitigation strategies; and
- The Bidder's corporate resources, including relevant previous experience, staff, computer facilities, financial stability, and corporate commitment to this contract.

4.2.6. Bidder Identification Information including Subcontractor Identification (Section 6)

Bidders will present the following identification information in this section:

- The organization's full company or corporate name;
- The address of the organization's headquarters office;
- How the entity is organized (proprietorship, partnership, corporation);
- An organization chart of the entity clearly depicting the Bidder's reporting relationship;
- The names and addresses of any parent organization, any partially or wholly owned subsidiaries, and any other related organizations;
- The state in which the Bidder is incorporated;
- The address of the Bidder's office location responsible for performance under the resulting contract if awarded the Contract; and
- The Bidder's Federal Tax Identification Number.

If the Bidder intends to subcontract any part of the scope of work to be performed under this Contract, the Bidder must indicate the following for each subcontractor:

- The subcontractor's name, address, and telephone number; and
- The subcontractor's intent to sign a formal agreement with the Bidder if the Bidder is awarded the Contract.

All subcontract agreements must be fully executed before the Contract with the selected Contractor is approved by the State.

4.2.7. Bidder Financial Information (Section 7)

The Bidder must demonstrate that its organization is in sound financial condition or that appropriate corrective measures are being taken to address and resolve any identified financial problems. The Bidder shall provide financial information in such a manner that the State can reasonably formulate a determination about

the stability and financial strength of the organization. This must include but not be limited to company size, organization, date of incorporation, ownership, number of employees, and revenues for the previous three (3) fiscal years. The Bidder must disclose any and all judgments, pending or expected litigation, or other real potential financial reversals that might materially affect the viability or stability of the Bidder's organization; or certify that no such condition is known to exist.

A current Dun and Bradstreet Report that includes a financial analysis of the organization would fulfill this requirement. A Bidder can use an Annual Report as verification of financial status, provided it contains at a minimum a Compiled Income Statement and Balance Sheet verified by a Certified Public Accounting firm. The State reserves the right to contact the accounting firm if questions arise. As an alternative, for those Bidders unable to provide audited financial statements or a Dun and Bradstreet Report, the Bidder shall provide tax returns and financial statements including income statements and balance sheets for the most recent three (3) years, and any available credit reports.

In the event a Bidder is either substantially or wholly owned by another corporate entity, the Bidder must also include the same information for the parent organization and a statement that the parent will unconditionally guarantee performance by the Bidder in each and every term, covenant, and condition of such contract as may be executed by the parties.

Any proposed subcontractor whose percentage of work to be performed (measured as percentage of total contract price) equals or exceeds 20 percent must submit the required information as well.

Additional financial information may be requested during the evaluation process.

4.2.8. Bidder Qualifications and Experience (Section 8)

Bidders must provide a detailed summary of contractor and subcontractor experience for its proposed project organization. Bidders must demonstrate an understanding of the scope of services; specifically knowledge of MMIS operations and services; knowledge of MMIS processes, inputs and outputs; knowledge of MMIS systems; and Medicaid program requirements.

Minimum Bidder qualifications, as listed in Section 2.3 of this RFP, are:

- The Bidder must be the prime FA (not a subcontractor) for a successful operation and maintenance of a state's certified MMIS for at least one (1) year;
- OR
- The Bidder must have been the prime FA for the successful implementation of a state's MMIS, for which certification was obtained.

Bidders must identify the appropriate categories of experience and the number of years and months of experience in each category listed below:

- Takeover and transition of an existing MMIS (Section 8.1);
- Enhancement of a MMIS (Section 8.2);
- Maintenance and Operation of a MMIS (Section 8.3);
- Implementation and Operation of Multi-Tiered Architecture, including Enterprise Service Buses (ESBs) and Web-based systems (Section 8.4);
- Hosting of a large-scale human services system such as MMIS, TANF, SNAP, SACWIS, and Child Support (Section 8.5);
- Hosting of other large-scale systems (Section 8.6); and
- Implementation of Care Management Commercial Off the Shelf software (COTS) or transfer applications (Section 8.7).

Bidders must provide responses for each category. If the Bidder has no experience in an area, it should clearly mark it “No Experience.” **Bidder and proposed subcontractor experience must be identified separately.**

For each of the seven categories, Bidders should provide the following details:

- Client name;
- Role of the Bidder;
- Scheduled and actual start and end dates of the project;
- Certification date of the system;
- Description of system software, programming language, databases, age, and size;
- Description of system architecture and related hardware;
- Description of contract scope and Bidder activities, noting similarities and differences with the Rhode Island scope of work in terms of size (annual claims and encounter transactions and dollars), scope, and complexity, including annual and total contract amounts; and
- A reference for the project, including client name, reference name, reference title, address, e-mail address, and telephone number.

Bidders must detail **all** experience in the following three categories for which the Bidder is or was prime contractor or a substantial subcontractor (more than 20 percent of the contract measured by total contract price) during the last ten (10) years:

- Transition of an existing MMIS (Section 8.1);
- Enhancement of an MMIS (Section 8.2); and
- Maintenance and Operation of a MMIS (Section 8.3).

The State reserves the right to conduct checks of Bidder references, by telephone or other means, and evaluate the Bidder based on these references.

It is the Bidder's responsibility to ensure that every reference contact is available during the evaluation period.

The Bidder's proposal must include a minimum of three (3) corporate references from three (3) separate and distinct projects that detail the proposers' experience in completing the tasks described in this RFP and that meet the minimum qualifications stated in Section 2.3 of this RFP.

Bidders should indicate their personnel commitment for all current (ongoing) contracts including new awards, not started in these three categories (Section 8.1, 8.2, 8.3). Bidders should describe how the Bidder and its partnering companies will address any potential conflicts between workload underway on those contracts with the Rhode Island MMIS project if awarded the Contract.

In addition to the experience in the seven categories, Bidders must provide the following information in this section:

- A list of prior and existing contracts or agreements that the Bidder has entered into with the State of Rhode Island; and
- A list of any persons named in the proposal (prime or subcontractor personnel) who is or was an employee of the State of Rhode Island in the past 12 months, including the name, State agency, job title, separation date, and the contract responsibilities of the person proposed; or a statement that no such relationship exists. If, after review of this information by the State, it is determined by the State that a conflict of interest exists or may exist, the Bidder may be disqualified from further consideration in this procurement.

If, at any time during the past three (3) years, the Bidder or any proposed subcontractor has had a contract terminated for convenience, nonperformance, non-allocation of funds, or any other reason, the Bidder must fully describe each termination and include the name, address, and telephone number of the contracting party and describe the circumstances surrounding the termination. If no such early terminations have occurred in the past three (3) years, the Bidder should include a statement to that effect.

4.2.9. Approach to Completing the Statement of Work (Section 9)

The State intends to enter into a separate contract with a Project Management Contractor to manage the State's Project Management Office (PMO) for the Transition, Enhancement, and Certification activities. The State also plans to enter into a separate contract with an Independent Validation and Verification (IV&V) contractor for the Transition and Enhancement activities. The MMIS FA is expected to cooperate fully with State staff and the contractors representing the State for PMO and IV&V services throughout all project activities.

Bidders' proposals must address how they will successfully complete the SOW for all activities listed in Section 5 of this RFP. Bidders' proposals must include the following sections:

1. Approach to Project Initiation and Start-Up Activities
2. Approach to Project Management
3. Approach to the Transition Activities
4. Approach to Maintenance and Operations
5. Approach to the Enhancement Activities
6. Approach to the Certification Activities
7. Approach to the Turnover Activities

The Bidder's proposed work plan and schedule must show completion of all Transition activities and assumption of start of all operations by nine (9) months following the Contract start date. Bidders may propose an alternative schedule for completion of Transition activities.

Bidders must propose a schedule for implementation of all enhancements for each enhancement or groups of enhancements in phases and the milestones and implementation dates when fully implemented.

The Enhancement activities are to start at the end of the Transition activities at the Start of Operations and are estimated to take thirteen (13) months for full implementation of all enhancements. Bidders may propose an alternate schedule to meet the requirements.

Bidders are asked to respond to the requirements of each major stage as defined in Section 5 of this RFP. If the Bidder has a different deliverable approach and methodology that meets or exceeds the objectives of the deliverables specified in this RFP, the Bidder must identify and describe its suggested deliverables and explain how they meet or exceed the objectives of the deliverables specified in this RFP.

Approach to Project Initiation and Start-Up Activities (Section 9.1)

This section of Bidders' proposals must address the following components described in Section 5.1 of this RFP:

- The approach to supporting Preliminary Planning activities between the approval of the Contract and the Contract start date
- The approach to leading and supporting Project Kick-Off meetings and related activities; and
- The approach to meeting Facility Readiness activities, including locating and establishing a local facility, the facility requirements, and schedule for setup and occupation.

Bidders must address the Staffing Readiness activities included in Section 5.1 of this RFP as part of their Approach to Project Staffing response in Section 10 of their Technical Proposals, as described in Section 4.2.10 of this RFP.

Approach to Project Management (Section 9.2)

This section of Bidders' proposals must address the following components described in Section 5.2 of this RFP:

- A high-level description of the project management approach and tasks that will be undertaken to perform the required work using the Project Management Plan (PMP);
- A list and description of project management deliverables needed to support the methodology and approach;
- A description of the approach to developing and maintaining the PMP;
- A preliminary Project Work Plan and Schedule that addresses major project activities and milestones; and
- The approach to managing the transition and enhancement activities using the PMP.

The PMP must address all project management subplans in the Bidder's approach, including: Integration, Scope, Time, Cost, Quality (including Testing), Human Resources, Communications and Risk.

Bidders' proposals must describe their approach to revising the Project Work Plan and Schedule as well as other sections of the PMP throughout the project lifecycle.

The Successful Bidder will be required to integrate project planning activities for all entities into its PMP throughout the course of the project. The PMP will be updated upon contract award and as agreed in the finalized PMP.

Bidder proposals must include:

- The Preliminary (proposed) Project Work Plan and Schedule; and
- A discussion of the Bidder's approach to Issue Resolution, Risk Management, and Change Management.

Approach to the Transition Activities (Section 9.3)

Bidders' proposals must describe the approach to transition of the Rhode Island MMIS and achieving Start of Operation within nine (9) months (or alternative proposed schedule) following the Contract start date. Bidders must describe the approach for meeting all requirements in Section 5.3 of this RFP. Bidders' proposals must include:

- A description of the approach to Transition activities and the tasks that will be undertaken to perform the required work;
- A list and description of Transition activities deliverables;
- Specific description of the Bidder's approach to transferring the Rhode Island MMIS to the vendor remote host facility, including the approach to:
 - o Analyzing requirements for hosting the Rhode Island MMIS and related systems on its hardware at a remote site. The Bidder must

- describe the proposed data center environment, including its proposed data center location (city, state), how the Bidder proposes to connect to the State network and how it intends to determine hosting requirements;
 - o Developing a plan for transfer of the MMIS and related system software;
 - o Testing the transfer of the MMIS and related system software
 - o Supporting Rhode Island user acceptance testing of the MMIS and related system software;
 - o Developing an approach to security, confidentiality, auditing and protection of personal health information;
 - o Updating system and user documentation, manuals, procedures and other documentation;
 - o Developing a backup and recovery plan to ensure that takeover and Transition activities will continue in the event the execution of backup and recovery is necessary. Bidder should describe which events may require backup and recovery exercises;
 - o Completing implementation of the Transition;
 - o Transfer of all applicable software licenses; and
 - o Addressing potential issues or risks in this transition and proposed mitigation strategies;
- Approach to assuming all responsibilities for ongoing transferring maintenance and operation of the current Rhode Island MMIS by the operational start date, including the approach to:
 - o Analyzing requirements for maintenance and operation of the current system;
 - o Reviewing current system documentation and operating procedures;
 - o Interviewing or otherwise obtaining additional information about undocumented systems or operations requirements;
 - o Transitioning responsibilities by the Bidder required for the successful transition of activities by the current FA;
 - o Meeting the defined operational requirements as defined in Sections 5 of this RFP and the Service Level Agreements (SLAs) as documented in Section 9.2.20 of this RFP and Appendix J to this RFP;
 - o Reporting on key performance indicators (KPIs);
 - o Verifying content of reports required for certification;
 - o Training FA, State, and provider staff;
 - o Identifying opportunities for business process redesign and communication of opportunities to the State;
 - o Conducting appropriate provider and user communications; and

- o Addressing any potential issues or risks in this transition and proposed mitigation strategies;
- Approach to demonstrating readiness to perform all successful MMIS FA functions and contractual requirements through an Operational Readiness Test, which will:
 - o Allow an estimated (as proposed) period of time for Operational Readiness Testing which will follow UAT;
 - o Ensure that all business areas are ready for production;
 - o Ensure that the MMIS FA is ready to process all inputs, price claim records correctly, meet all reporting requirements, use a properly functioning data communications network, and have a demonstrated backup capacity and meet all requirements in Section 5 of this RFP;
 - o Include a volume test of several days of production capacity claim records volumes to demonstrate that the MMIS and FA staff are prepared for full production;
 - o Demonstrate and verify physical data center security, data security, and fire/disaster prevention and recovery procedures; and
 - o Test disaster recovery processing, which will be limited to recovery during a daily and a weekly process cycle.

Approach to Maintenance and Operations(Section 9.4)

The Successful Bidder will operate the Rhode Island MMIS and related programs for a base five (5) year contract. The State may choose to activate additional three one-year options at its convenience. During the base contract and any optional years, the MMIS FA is expected to meet all requirements continuing ongoing operations of the current MMIS and implement the enhancements as described in Sections 6 and 7 of this RFP.

Bidders' proposals must describe the approach to assuming all responsibilities for ongoing Maintenance and Operations of the current Rhode Island MMIS as enhanced under Sections 5.5 and Sections 6, and 7 of this RFP, including the following:

- The Bidder's approach to Maintenance and Operations activities and the tasks that will be undertaken to perform the required work;
- A list and description of Maintenance and Operations deliverables;
- Specific descriptions of the Bidder's approach to the following operational responsibilities:
 - o Meeting the operational requirements as defined in Sections 5, 6, and 7 of this RFP and the SLAs, as documented in Section 9.2.20 and Appendix J to this RFP;
 - o Reporting on KPIs;

- o Updating system and user documentation, manuals, procedures and other documentation;
- o Training of FA, State, and provider staff;
- o Identifying opportunities for business process redesign and communication of opportunities to the State;
- o Conducting appropriate provider and user communications;
- o Addressing any potential issues or risks and proposed mitigation strategies; and
- o Communicating with Rhode Island staff to ensure that all program needs are being met, receiving feedback from staff, and responding to staff concerns;
- The Bidder's approach to managing, staffing and performing Maintenance activities, as described in Section 5.4.2 of this RFP;
- The Bidder's approach to managing, staffing and performing Modification activities, as described in Section 5.4.3 of this RFP; and
- The Bidder's approach to online and other reporting of Maintenance and Modification Work Requests as specified in Sections 5.4.2 and 5.4.3 of this RFP.

Approach to Enhancement Activities (Section 9.5)

Functional enhancements to the current MMIS are described in Sections 6.1 through 6.7 of this RFP. Technical enhancements are described in Section 7 of this RFP. Section 5.5 of this RFP describes FA responsibilities for completing Enhancement activities. Bidders' proposals must include the approach to implementing enhancements, including:

- Project Work Plan and Schedule for implementing each enhancement or group of enhancements within the guidelines stated in Section 4.2.9 of this RFP. Bidders' may include details and refer to the Project Work Plan and Schedule provided in Proposal Section 9.2 of this RFP;
- A description of the approach to Enhancement activities and the tasks that will be undertaken to perform the required work; and
- A list and description of Enhancement deliverables and the approval process

Specific descriptions of the Bidder's approach to the following operational responsibilities must include:

- An approach to requirements definition for each enhancement, including interaction with State staff;
- An approach to design of each enhancement, including contents of design documents;
- An approach to developing an interface architecture including proposed tools (e.g., middleware, etc.) and methods;

- An approach to defining detailed requirements for each interface and obtaining State acceptance of requirements;
- An approach to system testing, including development of system test plans, reporting test results, and use of any tools;
- An approach to building and maintaining a system testing environment;
- Quality assurance processes and requirements traceability;
- An approach to support of user acceptance testing of each enhancement;
- An approach to implementation of each enhancement;
- A change control process and the version control software; and
- An update of system and user documentation. Training of FA staff, providers, and users, including training plans and communications.

Approach to Certification Activities (Section 9.6)

The current Rhode Island MMIS is provisionally approved by CMS for operation of a MMIS and receipt of full FFP. CMS may certify only enhancements to the current MMIS or the entire MMIS as modified.

Bidders' proposals must present the approach to supporting the State during the CMS Certification Process, including:

- A list and description of Certification deliverables;
- A description of the approach to Certification activities as described in Section 5.6 of this RFP and the tasks that will be undertaken to perform the required work; and
- Specific descriptions of the following Certification responsibilities:
 - o Use and maintenance of the CMS Medicaid Enterprise Certification Toolkit Checklists throughout the project;
 - o Preparation of materials and documentation for the CMS onsite visit
 - o Participation in the CMS onsite visit as requested by the State; and
 - o Support and participation in responding to any follow-up actions required by CMS to obtain or maintain certification.

Approach to Turnover Activities (Section 9.7)

Bidders' proposals must address the approach to meeting all Turnover activities described in Section 5.7 of this RFP, including:

- A high-level description of the approach to Turnover activities and the tasks that will be undertaken to perform the required work; and
- A list and high-level description of Turnover activities deliverables.

4.2.10. Approach to Project Staffing (Section 10)

Staffing requirements are described in Sections 5.1, 9.2.49, and 9.2.50 of this RFP. Bidders will be required to provide qualified staff to perform all activities described in Section 5: Statement of Work, meet all responsibilities for operation of the current system as described in the Bidders' Library, and meet all Functional and Technical Requirements for enhancement of current functions contained in Sections 6 and 7 of this RFP.

This section of the Bidders' proposal will include the following sections:

1. Approach to Staffing for Transition Activities
2. Approach to Staffing for Maintenance and Operations
3. Approach to Staffing for Enhancement Activities
4. Project Organization Charts and Position Descriptions
5. Resumes of Key Personnel

Approach to Staffing for the Transition Activities (Section 10.1)

The Bidder should demonstrate an understanding of the appropriate staffing to complete the scope of work for the Transition activities as defined in Sections 5.1 through 5.7 of this RFP. Proposals should include the following:

- The number and types of staff required to complete the scope of work;
- Transition of personnel from Transition to Maintenance and Operations;
- Identification of any staff shared between Transition, Enhancement, and Maintenance and Operations activities and discussion of its strategy for managing the risk of overlapping staffing;
- A proposed staffing plan showing personnel categories and staffing equivalents for major categories of staff assigned to the Transition Activities, including modifications and special projects. The staffing plan should show key and non-key personnel staffing by category or person by month for the duration of the Transition activities; and
- A backup plan for replacement or supplementing staff if required.

Approach to Staffing for Maintenance and Operations (Section 10.2)

The Bidder should demonstrate an understanding of the appropriate staffing to complete the scope of work for Maintenance and Operations as defined in Section 5.4 of this RFP. Bidders discussion of Maintenance and Operations staffing must address staffing for modifications and special projects performed as a part of Maintenance and Operations as described in Section 5.4 of this RFP. Proposals should include the following:

- The number and types of staff required to complete the scope of work
- Identification of any staff shared between Maintenance and Operations and Enhancement activities, and a discussion of its strategy for managing the risk of overlapping staffing;

- A proposed staffing plan showing personnel categories and staffing equivalents for major categories of staff assigned to the Maintenance and Operations, including modifications and special projects. The staffing plan should show key and non-key personnel staffing by category or person by month for the duration of Maintenance and Operations; and
- A backup plan for replacement or supplementing staff if required.

Approach to Staffing for the Enhancement Activities (Section 10.3)

The Bidder should demonstrate an understanding of the appropriate staffing to complete the scope of work for the Enhancement activities as defined in Section 5.5 of this RFP. Proposals should include the following:

- The number and types of staff required to complete the scope of work;
- A proposed staffing plan showing personnel categories and staffing equivalents for major categories of staff assigned to the Enhancement activities. The staffing plan should show key and non-key personnel staffing by category or person by month for the duration of the Enhancement activities; and
- A backup plan for replacement or supplementing staff if required.

Project Organization Charts and Position Descriptions (Section 10.4)

Bidders' proposals should include distinct organization charts for the three major activities:

- Transition;
- Maintenance and Operations; and
- Enhancement.

Proposals should also include descriptions of staffing positions shown in the organization chart and listed in the staffing charts in Sections 10.1, 10.2 and 10.3.

Key Personnel (Section 10.5)

Bidders must identify and describe roles and responsibilities of the following key personnel:

- Executive Account Manager
- Project Manager (Deputy Account Manager)
- Systems Operations Manager
- Provider Services Manager
- Claims Manager
- Data Manager

- Transition Manager
- Enhancement Manager

Bidders may propose multiple roles for a key person, but overlapping responsibilities and transition between roles must be explained. Responses that do not identify the persons proposed for the positions by name will be rejected as non-responsive.

This section must include resumes and short narrative descriptions summarizing relevant experience of all proposed key personnel. Resumes should include relevant project experience, description of the person's role on the project, dates of participation, and three personal references with names, addresses, telephone numbers and e-mail addresses.

4.2.11. Approach to Meeting Functional and Technical Requirements (Section 11)

Bidders must acknowledge the capability and willingness to meet all requirements for continuing operations of the current Rhode Island MMIS and implementing the required functional and technical enhancements as defined in Sections 6 and 7 of this RFP.

Bidders' Proposals must include the following sections:

1. Approach to Meeting Requirements for Functional Enhancements
2. Approach to Meeting Requirements for Technical Enhancements
3. Approach to Meeting Current MMIS Functional and Technical Requirements

Approach to Meeting Requirements for Functional Enhancements (Section 11.1)

Bidders' Proposals must include the approach for meeting functional requirements for enhancements as described in Sections 6.1 through 6.7 of this RFP, including:

- Care Management Requirements (Section 11.1.1);
- Requirements Supporting Cost Savings Initiatives (Section 11.1.2);
- Customer Service Requirements (Section 11.1.3);
- Claims Processing Requirements (Section 11.1.4);
- Eligibility (Beneficiary Management Requirements) (Section 11.1.5);
- Managed Care Requirements (Section 11.1.6); and
- Financial and Program Management Requirements (Section 11.1.7).

For the first three enhancements (Sections 11.1.1 through 11.1.3), each section must include:

- A narrative description of the Bidder's approach to meeting enhancements in each of the three areas. The detailed narrative description for the Care Management, Requirements Supporting Cost Savings Initiatives and Customer Service Requirements must identify:
 - o The proposed COTS or transfer application;
 - o Reason for selection of the COTS or transfer application for meeting Rhode Island's requirements;
 - o Bidder's experience with the COTS or transfer application, including names of clients, years of use, and summary of advantages and disadvantages; and
 - o Proposed approach, schedule, staffing and deliverables as described in Section 5.5 of this RFP.
- Completion of the Requirements Checklists for Care Management, Requirements Supporting Cost Savings Initiatives, and Customer Service Requirements.

The requirements are organized as Inputs, Processing, Outputs, Interfaces, and FA Responsibilities.

Functional requirements for enhancements are presented in table format as shown in Table 10. Complete checklists are included in Appendix O.1 to this RFP. Bidders must complete the tables and include them in the proposal. The following tables are illustrative:

- **ID** – Unique requirement identifier.
- **State Requirement** – Description of the requirement.
- **Bidder Acknowledgment** (To be completed by Bidder) – Bidder acknowledges and accepts responsibility for meeting the requirement by checking the box in the column.
- **Response Code** (To be completed by Bidder) – For use with requirements related to implementation of a COTS or transfer application. Bidders should enter the one and only one of the response codes in Table 9 for each requirement.

If the requirement does not refer to a COTS or transfer application, the column requiring a Response Code is marked "N/A." Bidders must enter a response code for all requirements not marked N/A.

Table 9: Response Codes for Requirements Tables

Response Code	Definition
E – Existing	Requirement or service will be met by existing software or processes that are installed and operational at other sites and can be incorporated as is or using the software's standard configuration mechanisms.
M – Minor Modification	Requirement or service will be met by proposed minor modifications to existing software or processes beyond using the software's

Response Code	Definition
	standard configuration mechanisms.
R – Ancillary Tool or Service	Requirement or service will be met by the use of integrated software tools, such as a report writer, query language or spreadsheet package or through an ancillary service provider.
X – Will Not Provide	Bidder will not meet requirement or service.

- **Bidder Considerations** (To be completed by Bidder) - Available for Bidder to include additional information. Not a required field.
- **Proposal Reference** (To be completed by Bidder) - Available for Bidder to reference additional information related to requirements in other sections of proposal. Not a required field.

Table 10: Requirements Checklist for Care Management, Requirements Supporting Cost Savings Initiatives, and Customer Service Requirements

ID	State Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
4.X.X. Inputs					
CM.1		☐	N/A		
CM.2		☐			
CM.3		☐			
CM.4		☐			
CM.5		☐			
4.X.X Processing					
CM.6		☐			
CM.7		☐			

For the last four enhancements (Sections 11.1.4 through 11.1.7), each section must include:

- A narrative description of the Bidder's approach to meeting enhancements in each of the four areas. The detailed narrative description for the Claims Processing Requirements (Section 11.1.4), Eligibility (Beneficiary Management Requirements) (Section 11.1.5), Managed Care

Requirements (Section 11.1.6) and Financial and Program Management Requirements (Section 11.1.7) must identify the proposed approach, schedule, staffing, and deliverables as described in Section 5.5 of this RFP; and

- Completion of the Claims Processing Requirements, Eligibility (Beneficiary Management Requirements), Managed Care Requirements, and Financial and Program Management Requirements. The requirements are organized as Inputs, Processing, Outputs, Interfaces, and FA Responsibilities.

Functional requirements for enhancements are presented in table format as shown in Table 11. Complete checklists are included in Appendix O.2 to this RFP. Bidders must complete the tables and include them in the proposal. The table data includes:

- **ID** – Unique requirement identifier.
- **State Requirement** – Description of the requirement.
- **Bidder Acknowledgment** (To be completed by Bidder) – Bidder acknowledges and accepts responsibility for meeting the requirement by checking the box in the column.

Table 11: Requirements Checklist for Claims Processing Requirements, Eligibility (Beneficiary Management Requirements), Managed Care Requirements, and Financial and Program Management Requirements

ID	State Requirement	Bidder Acknowledgment
CLM.1		☐
CLM.2		☐
CLM.3		☐
CLM.4		☐
CLM.5		☐

Approach to Meeting Requirements for Technical Enhancements (Section 11.2)

Bidders' Proposals must include the approach for meeting requirements for the two technical enhancements as described in Sections 7.1 through 7.2 of this RFP:

- Web Foundation Requirements (Section 11.2.1); and
- ESB Requirements (Section 11.2.2).

Each of the two sections listed above must include:

- A narrative description of the Bidder's approach to meeting the technical enhancements, including a description of the architectural design,

structural design, assumptions and security. The detailed narrative description must identify the proposed approach, schedule, staffing and deliverables as described in Section 5.5 of this RFP;

- A pictorial depiction of how the proposed solution fits into the Rhode Island IT architecture based on the technical requirements specified in this RFP and the environment information provided in Sections 3.5 through 3.7 of this RFP; and
- Completion of the Requirements Checklists for the Technical Enhancements.

Requirements for enhancements to technical requirements are presented in table format as shown in Table 12. Complete checklists are included in Appendix O.3 to this RFP. Bidders must complete the tables and include them in the proposal. The table data includes:

- **ID** – Unique requirement identifier.
- **State Requirement** – Description of the requirement.
- **Bidder Acknowledgment** (To be completed by Bidder) – Bidder acknowledges and accepts responsibility for meeting the requirement by checking the box in the column.

Table 12: Requirements Checklist for Technical Enhancements

ID	State Requirement	Bidder Acknowledgment
ESB.1		☐
ESB.2		☐
ESB.3		☐
ESB.4		☐
ESB.5		☐

Approach to Meeting All Current Functional and Technical Requirements (Section 11.3)

Bidders' proposals must include the approach for meeting all current functional and technical requirements for operation of the Rhode Island MMIS and related systems. Bidders should carefully review the information provided in the Bidders' Library to obtain an understanding of the current requirements.

In addition, Bidders should use their expertise in MMIS, Medicaid, and FA services to ensure that any additional requirements required for the implementation and operation of the MMIS and related systems beyond those specifically stated in this RFP and accompanying documentation are included in

their bids and considered in all aspects of their proposal. Final clarification of requirements will be determined during the Joint Application Design sessions with users.

The MMIS FA is responsible for ensuring certification of the MMIS SS-A. The CMS required Medicaid Enterprise Certification Toolkit Checklists issued September 28, 2007 are included in the Bidder's Library. The checklists contain a set of business objectives by business area and a set of system review criteria for each objective. State-Specific business objectives are highlighted and uniquely numbered and include "SS" to indicate State-Specific checklist items. State business objectives are directly tied to the functional requirements contained in this RFP. Bidders are responsible for maintaining the checklists throughout the project, incorporating the most recent versions issued by CMS.

In preparation for this RFP, the State completed a MITA SS-A. The MITA SS-A included an assessment of Rhode Island's Medicaid's current business capabilities as measured using the MITA Business Capability Matrix (MITA BCM). Current levels of maturity for each MMIS business process within the Medicaid program were documented to establish a baseline capability profile.

Portions of the MITA SS-A have been included in the Bidders' Library. The following table includes a listing of all current Rhode Island business processes that include MMIS processing. Bidders are required to acknowledge transition and maintenance of each business process.

Bidders' proposals must include the following sections confirming their willingness and ability to meet all requirements for operating the Rhode Island MMIS as enhanced:

- A narrative describing the Bidder's approach to ensure and understanding of all Rhode Island requirements (Section 11.3.1);
- Bidder acknowledgment of all CMS-required Medicaid Enterprise Certification Toolkit Checklists in Appendix O.4 to this RFP (Section 11.3.2). Bidders are required to complete the Checklist for Acknowledgment of Business Objectives for Enhancements, and include it in their proposals. The checklist is presented in the format shown in Table 13. Bidder acknowledges and accepts responsibility for the CMS Certification Requirements by checking the box in the column "Bidder Acknowledgment."

Table 13: Checklist for Acknowledgment of Business Objectives for Enhancements

ID	CMS Checklist	Bidder Acknowledgment
Beneficiary Management Business Area		
CMS.1.	Beneficiary Management Checklist	☐
Provider Management Business Area		

ID	CMS Checklist	Bidder Acknowledgment
CMS.2.	Provider Management Checklist	☐

- Bidder acknowledgment of the transition and maintenance of each MITA business process described in the MITA Current View of Rhode Island Medicaid of the MITA SS-A contained in the Bidders' Library (Section 11.3.3). Bidders must complete the Checklist for Acknowledgment of Current MITA Business Processes in Appendix O.5 to this RFP and include it in their Proposals. The checklist is presented in the format shown in Table 14. Bidder acknowledges and accepts responsibility for operation of the current MITA business processes by checking the box in the column "Bidder Acknowledgment"

Table 14: Checklist for Acknowledgment of Current MITA Business Processes

ID	MITA Business Process	Bidder Acknowledgment
Beneficiary Management Business Area		
CMS.1.	Beneficiary Management Checklist	☐
Provider Management Business Area		
CMS.2.	Provider Management Checklist	☐

- Bidder acknowledgment of the transition and maintenance of all current MMIS technical capabilities as described in Section 5.3.2 of this RFP (Section 11.3.4). Bidders must complete the table in Appendix O.6 to this RFP and include it in their proposals. The checklist is presented in the format shown in Table 15. Bidder acknowledges and accepts responsibility for operation of the current technical capabilities by checking the box in the column "Bidder Acknowledgment"

Table 15: Transition of Current MMIS Technical Capabilities

ID	State Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
4.X.X.					
TR.1	The Transition MMIS must be hosted in an enterprise data center.	☐	N/A		
TR.2	The Transition MMIS must have a system	☐			

ID	State Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
	backup plan.				

- Bidder acknowledgment of the transition of all FA responsibilities, including those listed in Section 5.4.1 of this RFP. (Section 11.3.5) Bidders must complete the table in Appendix O.7 to this RFP and include it in their Proposals. The checklist is presented in the format shown in Table 16. Bidder acknowledges and accepts responsibility for operation of the current technical capabilities by checking the box in the column “Bidder Acknowledgment.”

Table 16: Transition of Fiscal Agent Responsibilities

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
	Operations Management Business Area	
<i>OPS.1.0</i>	<i>Claims Processing</i>	☐

4.3. Cost Proposal Requirements

Bidders must submit five (5) hard copies of the Cost Proposal with original signatures, marked “Original Cost Proposal #1” through “Original Cost Proposal #5.” Bidders must also submit five (5) electronic copies of the Cost Proposal on CD-ROM in Microsoft Office 2003 or Adobe Acrobat format.

The Cost Proposal shall be clearly labeled as “Cost Proposal” and included as a separate sealed document from the Technical Proposal within the box or envelope containing the Bidder’s proposal.

Bidders must submit Cost Proposals in the order specified and number the sections of their response using the following section numbers:

1. Executive Summary
2. Mandatory Cost Proposal Requirements Checklist
3. Pricing Schedule for the Total Project
4. Pricing Schedule for Enhancement Activities
5. Pricing Schedules for Maintenance and Operations Activities

Proposals must be printed on 8½ X 11 inch paper (letter size) double-sided. Proposals must be single-spaced, and the text font must be no smaller than 12 points. Tables and figures may be in smaller font, but must be legible.

Templates for Pricing Schedules are included in Appendix N to this RFP. For each schedule, where a signature block is indicated, an appropriate corporate official must sign and date the schedule. Instructions for completing each schedule are included in the following sections. If any variations exist between the summary schedules and the other schedules and no clarification appears, the summary pricing schedules will prevail. It is the Bidder's responsibility to identify any missing cost items, and missing items will be the responsibility of the Bidder. The State may assign an appropriate cost to the missing item to prevent a perceived cost advantage over another Bidder.

4.3.1. Executive Summary (Section 1)

Bidders' Cost Proposals must include an Executive Summary of not more than three (3) pages. The Executive Summary should summarize and highlight relevant contents of the Cost Proposal to provide State administrators and the Evaluation Committee with a broad understanding of the Bidder's Cost Proposal. The Executive Summary should include a statement certifying that all pricing information presented as part of the proposal is in U.S. dollars and that all required cost information is enclosed.

4.3.2. Mandatory Cost Proposal Requirements Checklist (Section 2)

Bidders must complete and submit a Mandatory Cost Proposal Submission Requirements Checklist. All copies must contain original signatures. The template for the Mandatory Cost Proposal Submission Requirements Checklist is included in Appendix M.2 to this RFP.

4.3.3. Cost Schedule for the Total Project (Section 3)

Bidders must submit the proposed Total Project Price on Pricing Schedule A. Pricing Schedule A must include the following:

- Total Price for Enhancement Activities from Pricing Schedule B;
- Total Evaluated Price for the Five (5) Base Contract years from Pricing Schedules C.1 through C.5; and
- Total Evaluated Project Price, which is the sum of the above.

4.3.4. Cost Schedules for Enhancement Activities (Section 4)

On Pricing Schedule B, Bidders must submit a firm fixed price for each of the nine (9) enhancements specified in this RFP. Bidders must categorize each price into the categories shown in the table on Pricing Schedule B as follows:

1. Personnel and Labor
2. Facilities
3. Equipment

4. Network and Communications
5. Testing
6. Training
7. Data Conversion and Implementation
8. Other Costs, including Travel

Bidders must include a firm fixed price for implementation of each of the nine enhancements. Any ongoing costs for maintenance and operations following implementation of an enhancement should be reflected in the appropriate Pricing Schedules for subsequent Maintenance and Operations Pricing Schedules for the years following the implementation.

The successful FA will be paid for Enhancement activities as stated in Section 9.2.21 of this RFP.

4.3.5. **Pricing Schedules for Maintenance and Operations Activities (Section 5)**

Bidders must bid a Total Evaluated Cost that includes all operations functions, services, maintenance, modifications and staffing for systems operations as defined in the RFP for each of the five (5) base contract years. Bidders will complete Schedules C.1 through C.5 for each of the five years of the base contract beginning on the operational start date in the contract. Optional years will be priced at the price for Base Year 5, subject to any negotiated cost of living increase.

Bidders must categorize the Total Evaluated Cost for each contract year into the two major categories shown in the table on Pricing Schedule C:

- MMIS System Price
- Modification Price

The **MMIS System Price** includes the following:

- Core services for maintenance and operation of the MMIS and related systems (as defined in Section 5.4 of this RFP);
- Professional services including services by Preferred Drug List staff, enrollment broker for Rhody Health Partners, Web translation services, SAS Type II audits, radiology management, process improvement team, clinical prior authorization consultants and all other professional staff supporting the maintenance and operation of the MMIS as specified in Section 5.4 of this RFP; and
- Transaction processing services for all types of transactions
- A maximum for two thousand (2,000) hours of modifications over the five (5)-year contract period included in the **MMIS System Price**.

The **MMIS System Price** must be itemized by the Bidder into the following line items:

- MMIS Operations Price

- o Core MMIS
- o Pharmacy Point-of-Sale
- o Pharmacy Rebate
- o Clinical Claims Review
- o EOHHS Data Warehouse
- o Web Portal
- Claims Processing Support Services
 - o Provider Call Center
 - o Provider Enrollment
 - o Provider Training and Outreach
 - o ID Card Processing
 - o Premium Billing and Expenses
 - o Prior Authorizations
 - o Utilization Management
- Transaction Processing Cost
- Other Costs
 - o Travel
 - o Other (listed)

The Transaction Processing Cost is the cost for processing of all transactions, including encounters, claims, capitation and premium payments. The Transaction Processing Cost is provided by the Bidder for information only. All transaction processing services are included in the firm, fixed MMIS System Price. Estimated annual transaction volumes for SFY 2010 are listed in the following table for Bidder consideration in providing the Transaction Processing Cost:

Table 17: Estimated Annual Transaction Volumes for SFY 2010

Transaction Type	SFY 2010 Estimated Volume
Claims	5,200,000
Encounters	3,800,000
Pharmacy Transactions	1,200,000
CNOM (Non-Claims) Transactions	135,000
Capitation Payments	142,000
Premium Payments	390,000

The **Modification Price** is a single, all-inclusive hourly rate for customer-required changes prioritized and approved by the Medicaid agency. The single all-

inclusive hourly rate includes all personnel, overhead, indirect, travel, profit, equipment usage, and other miscellaneous costs. The single all-inclusive hourly rate is to be used for all labor categories.

An estimated number of modification hours is provided on each schedule for evaluation purposes only. The actual volume of modification hours for payment may exceed or be less than the number used for evaluation purposes. Annual modifications hours for previous State fiscal years are listed in the following table:

Table 18: Annual Modifications Hours for Previous SFYs

Modification Hours	Estimated Volume
SFY 2010	20,000
SFY 2009	20,000
SFY 2008	20,000
SFY 2007	20,000

The State provides this information for Bidder staff planning. Payment will be made on actual hours used. The State does not guarantee any minimum number of modification hours.

The ***Total Evaluated Price for each base contract year*** will be invoiced on a monthly basis in equal monthly payments. The State will authorize monthly payments for maintenance and operations services upon approved invoices submitted by the FA. Payments will be provided in accordance with Sections 9.2.17 through 9.2.19 of this RFP. All payments will be based on provisions for SLAs as described in Section 9.2.20 and Appendix J to this RFP.

In addition to monthly payments for maintenance and operations services and approved modifications, the Department may authorize payments for Special Projects. Special Projects are defined as additional services available to EOHHS on a time and materials or per diem basis as negotiated by project or activity. These activities, which are anticipated to be in support of State health care initiatives, may include enhanced professional services, clinical expertise, technical support to eliminate Department backlogs, outreach efforts, etc. Special Projects may include funding from State-only programs and grants.

Postage will be billed to the State as a pass-through expense and will not be included in Pricing Schedules C.1 through C.5. Pass-through expenses include costs for identification card mailings, post office box fees, express or parcel mailings, other carrier costs and actual metered amounts incurred by the FA on a monthly basis.

The following will not be authorized for payment:

- The State will authorize no payments for operations and maintenance other than the ***MMIS System Price***, payment for authorized Special Projects,

and payment for modification hours approved by the State as defined in this section;

- The State will authorize no payments for takeover and transition activities as described in Section 9.2.18 of this RFP. Payments for the first contract year will begin on the start of full contract operations upon approval of all deliverables for takeover and transition activities; and
- The State will authorize no payments for turnover activities as described in Section 9.2.18 of this RFP.

5. Statement of Work

Rhode Island has developed a set of enhancements to ensure its MMIS and supporting systems are able to respond to the changing environment that health care reform brings. The new regulations issued by CMS in response to the Patient Protection and Affordable Care Act (ACA) include updates to MITA and new conditions for obtaining federal funding to upgrade systems to meet expanded eligibility requirements. The State requires Bidders responding to this SOW to present an approach that meets the Seven Conditions and Standards contained in CMS Medicaid IT Supplement, MITS-11-01-v1.0, released in April 2011. Architectural and design solutions proposed must meet MITA goals of service-oriented architecture (SOA) and business driven processes.

The estimated schedule of events for the Rhode Island MMIS Takeover, Enhancement, Operation, and Maintenance is listed in RFP Section 1: Overview of the Procurement. The State expects each Bidder to submit a Project Work Plan and Schedule to support its proposed schedule for project tasks and activities. Upon contract award, the State will finalize the schedule with the selected FA. Project activities and suggested timeframes for MMIS Takeover, Enhancement, Operation, and Maintenance activities are as follows:

Table 19: Project Activities and Suggested Timeframes

Activity	Suggested Timeframe
Transaction Activities	Completed no later than nine (9) months following the Contract Start Date unless otherwise proposed and approved by the State in the final Contract
Maintenance and Operations	Five (5) years from the Start of Operations (completion of Transition) with three (3) optional one-year extensions
Enhancement Activities	Thirteen (13) months following the Start of Operations (approval of completion of Transition Activities) unless otherwise proposed and approved the State in the final Contract
Certification Activities	Following completion of Enhancement Activities in preparation for the CMS certification review as scheduled by the State and CMS
Turnover Activities	At contract completion (six months prior to contract end or as specified by the State)

The SOW for this project involves takeover of the current Rhode Island MMIS, transition of current operations to the new MMIS FA staff and facilities, maintenance and operation of the current MMIS, implementation of the nine (9) enhancements detailed in Sections 6 and 7 of this RFP, certification of the enhanced system, and turnover of the MMIS and related systems to the next MMIS FA at contract end. This SOW includes seven (7) major activities:

- Project Initiation and Start-Up Activities (Section 5.1 of this RFP)
- Project Management (Section 5.2 of this RFP)
- Transition Activities (Section 5.3 of this RFP)
- Maintenance and Operations (Section 5.4 of this RFP)
- Enhancement Activities (Section 5.5 of this RFP)
- Certification Activities (Section 5.6 of this RFP)
- Turnover Activities (Section 5.7 of this RFP)

In preparing their responses, Bidders are advised to consult the State's MITA SS-A goals and objectives, which are the basis for the activities described in this RFP. Bidders are directed to the Bidders' Library for additional information regarding the MITA SS-A, documentation of current systems, and descriptions of processes that are referenced in this RFP. The following sections detail MMIS FA responsibilities for the major tasks.

5.1. Project Initiation and Start-Up Activities

The Project Initiation and Start-Up activities will begin upon execution of the MMIS FA contract for services required by this RFP. With these activities, the State and MMIS FA set the foundation for all subsequent project activities. The Project Initiation and Start-up activities include:

- Preliminary Planning activities
- Project Kick-Off
- Facility Readiness activities
- Staffing Readiness activities

Project Initiation and Start-Up activities will not commence until State approval of the contract and execution of a purchase order, including identification of the Contract start date.

Preliminary Planning

The Preliminary Planning activities are those that occur between Contract execution and the Contract start date. The purpose of these activities is to ensure that both the State and MMIS FA are prepared to fully initiate project activities on the Contract start date without delays.

Activities for this stage include initiation of project communications, introduction of the respective project teams, detailing of specific items negotiated in the contracted scope of work, and preparation of all teams and facilities for full project initiation on the Contract start date. The MMIS FA will ensure the availability of project management staff to ensure adequate planning occurs prior to project start.

Project Kick-Off

The MMIS FA will be responsible for planning and leading Project Kick-Off activities. The FA will propose a meeting or series of Kick-off meeting(s) for State approval. Kick-off meeting(s) will be attended by State and FA representatives. The State will specify the participation of the State's IV&V Contractor and Project Management Contractor at all or some of the Kick-off activities. Participation of the current FA will be dictated by the State.

Kick-off activities will focus on setting the foundation for project management activities, which will be fully defined in the Project Management Activity (Section 5.2 of this RFP). Issues and topics may include:

- Review of project objectives and program status;
- Updates on State activities since publication of the RFP;
- Preliminary project work plan and schedule discussions;
- Format and content of project status meetings;
- Format and content of status reports;
- Communications protocols and reporting relationships;
- Issue resolution responsibilities and processes;
- Initial discussion of project risks; and
- Deliverable review responsibilities and processes.

Facility Readiness

The FA must identify the location where it will perform each MMIS-related and FA service function. The State requires that the FA maintain a facility within a 10-mile radius of the Hazard Building in Cranston, Rhode Island, where the official Agency liaison to the FA is located throughout the term of the contract.

The FA local facility will be open for operations and available for access by EOHHS during normal business hours from 8:00 AM to 5:00 PM ET with the exception of weekends and Rhode Island State holidays.

The FA local facility must have office space for two (2) State staff. The office space must be equipped with:

- Telephone and high-speed Internet service;
- Personal computers with access to the MMIS and related systems; and
- Access to printing, copying and facsimile equipment.

The FA local facility must have a conference room that accommodates meetings of up to fifty (50) persons. The State may schedule the conference room at any time during business hours. The FA local facility must have adequate parking and access for disabled persons.

The local facility must be available within six (6) months after the Contract start date and prior to the Operations start date. For the Project Initiation and Start-Up and Transition activities that occur prior to establishment of the local facility, the FA must provide adequate meeting facilities to accommodate these activities.

The FA must provide courier service between the FA's local facility and the Rhode Island Hazard building. Pickup and delivery will be provided daily on a schedule agreed to by the State.

All MMIS functions and associated staff must be performed at the local FA facility unless otherwise approved by the State. Enhancement activities, certain system modifications, radiology management services and other Rhode Island MMIS functions may be performed outside of Rhode Island but within the continental United States if approved in advance by the State.

Staffing Readiness

The State has identified the key personnel required to support the Rhode Island MMIS Takeover, Enhancement, Operation and Maintenance activities. Key personnel are:

- Executive Account Manager
- Project Manager (Deputy Account Manager)
- Systems Operations Manager
- Provider Services Manager
- Claims Manager
- Data Manager
- Transition Manager
- Enhancement Manager

Bidders may propose multiple roles for a key person, but must explain any overlapping responsibilities and transition between roles.

Key personnel must be assigned to the project on a fulltime basis, solely dedicated to the Rhode Island account, and located onsite at the Rhode Island local facility. The Transition and Enhancement Managers must be located in Rhode Island fulltime through the duration of their respective phase activities. Section 4.2.10 of this RFP describes provisions for management of key personnel throughout the contract.

In addition to key personnel, the MMIS FA must provide sufficient staff to perform all FA responsibilities outlined in this RFP and meet all SLAs. Documentation of FA responsibilities to support the current system is included in the Bidders' Library. The following table indicates examples of types of staff and requirements for dedicated time and onsite presence. Bidders should note that not all staff are

included in the table. If clarification is needed, it is the responsibility of the Bidder to pose questions during the procurement process.

Table 20: Examples of Types of Staff and Requirements for Dedicated Time and Onsite Presence

Category/Function	Description	Dedicated 100%?
Account Management.	Account manager(s), analysts, administrative assistants, etc.	Yes
Claims Staff	Claims managers, mailroom, document control, data entry, suspense resolution	Yes
Provider Services	Provider Services manager, provider representatives, trainers, Call Center, enrollment, EDI coordinator	Yes
Drug Rebate Staff	Rebate coordinators	Yes
SURS Staff	Registered nurses who review claim data, medical records, and compares data to Medicaid policy to verify payment. A minimum of 50 cases are reviewed each quarter along with the initiation of special projects	Yes
Prior Authorization Staff	Specialists to review PAs or route to specified RI staff; manage receipt of requests, data entry and generate notices	Yes
TPL	Specialists to process and verify TPL information from InRhodes, providers, claims data, and COB updates, generate invoices for recovery payments, apply recovery payments and respond to questions from the State and providers	Yes
Financial Services	Staff to apply accounts receivable/ payable, adjustments, payments, premium processing	Yes
Reference Data Maintenance	Staff to maintain reference files	Yes
Systems Maintenance and Modification Staff	Industry-qualified staff to perform release management, version control, extracts, documentation maintenance, network and database management, and other technical personnel as required to maintain all other system components	Systems Manager and Maintenance Staff
Data Team	Industry-qualified staff to create and generate routine and ad hoc reports	Yes
Pharmacy Management	Automated prior authorization during the point-of-sale transaction, lock-in, Drug Utilization Review (DUR), and management of drug rebates	No
Premium Collection	Staff to support RiteShare business processes	Yes
Preferred Drug List (PDL)	Pharmacy and Therapeutics (P & T) Committee	Yes

Committee	support along with administration of the Supplemental Rebate Program; provides payments to up to 10 P&T Committee members for attendance at quarterly meetings	
Enrollment Broker for Managed Care Options for Adults with Disabilities	Bilingual recipient helpdesk to support the enrollment of adults on Medicaid into managed care options, including Connect Care Choice and Rhody Health Partners	Yes
Radiology Management Staff	Prior authorization for high-cost imaging services (e.g. PET, MRI, CT, etc.), including a provider help desk	No
Process Improvement Team	Research of potential cost savings solutions and other special projects as assigned	Yes
Web Directory Services (Ask Rhody)	Maintenance of the Web directory in English, Spanish and Portuguese	Yes
Clinical Consultants	Two (2) Clinical Consultants trained as psychologist, one (1) trained as a physical therapist and one (1) trained as an occupational therapist	Yes
Dental Benefits Manager (DBM)	Data entry of DBM enrollments	Yes
Children's Health Account P.O. Box	Generates invoices to insurance companies; receives payments and posts against the AR	Yes
Dental Consultants	Two (2) Dental Consultants credentialed in orthodontics to review PA requests	Yes
Incentive Payments/Cards	Issues and mails incentive cards to recipients and coordinates the funding of the account	Yes

5.1.2. Deliverables

The FA will prepare the following deliverables in support of Project Initiation and Start-Up activities:

- Agendas and minutes for Project Kick-off meetings.

5.1.3. Fiscal Agent Responsibilities

The FA will support Project Initiation and Start-Up activities as follows:

- Make available appropriate project management staff to ensure adequate planning occurs prior to project start;
- Plan and lead project Kick-Off Activities as described in Section 5.1.1 of this RFP;
- Provide facilities and meeting space for project activities prior to the availability of the FA local facility;

- Establish a local facility within a 10-mile radius of the Hazard Building in Cranston, Rhode Island;
- Provide daily courier service between the State Hazard Building and the FA permanent and temporary local facilities beginning on the Contract start date;
- Assign and maintain key personnel in accordance with Section 9.2.49 and 9.2.50 of this RFP; and
- Provide sufficient staff to perform all FA responsibilities as outlined in Sections 5, 6 and 7 of this RFP and meet all specified SLAs.

5.1.4. State Responsibilities

The State will support Project Initiation and Start-Up activities as follows:

- Make available appropriate project management staff to ensure adequate planning occurs prior to project start;
- Attend Kick-off meetings;
- Provide the FA with agenda topics for Kick-off meetings;
- Coordinate participation of the current FA, Project Management Contractor, and IV&V staff in Project Initiation and Start-Up activities;
- Keep the FA apprised of ongoing changes to the Medical Assistance and related programs during the Project Initiation and Start-Up period; and
- Provide coordination with CMS, and report any relevant information, instructions or requirements to the FA.

5.2. Project Management Activities

Project Management is the application of knowledge, skills, tools, and techniques to project activities to meet project requirements. The Project Management tasks consist of the Bidder's approach to planning, reporting, and meeting resource requirements throughout the term of the contract. EOHHS expects the Bidder to present a clear understanding of the methods and tools used to ensure that its resources are managed to complete required tasks and deliverables.

The Bidder's proposal must describe its Project Management process in sufficient detail to provide the EOHHS with an understanding of its approach. Requirements for Bidders' proposals are found in this RFP at Section 4: Proposal Submission Requirements. A preliminary Project Work Plan and Schedule must be submitted with the Technical Proposal.

Each Project Management Knowledge Area is described below and is required to be addressed in the FA's PMP.

The FA will be required to produce, and execute a PMP addressing all phases of the project within 30 days of Contract start. This plan will be updated throughout the project. Minimally, 30 days prior to the initiation of each phase, the PMP

must be updated with detailed information for that phase. The PMP shall be based on the FA's methodology and adhere to the Project Management Institute (PMI) standards contained in IEEE 1490-2003 Adoption of the PMI Standard. The PMP will address all Project Management Knowledge Areas defined in the IEEE standard, including: Integration, Scope, Time, Cost, Quality, Human Resources, Communications, Risk, and Procurement.

The major Project Management Activities are described below.

Project Integration Management

Project Integration Management includes all the processes and activities needed to identify, define, combine, unify, and coordinate the various processes and project management activities. The PMP will define how the FA will execute, monitor, control, and close the project. Each phase of the Transition, Enhancement, Operation, and Maintenance project will need to be addressed.

Change Management is a key part of Project Integration Management. The Integrated Change Control process is performed throughout the lifecycle of the contract. The purpose of change management is to ensure the project scope and configured items are formally controlled. The change management process provides the capability to identify, accept, evaluate, determine, and communicate the disposition of issues that result in changes to project scope or configured items.

Project Scope Management

Project Scope Management includes all the processes required to ensure the project requirements are met. The PMP will include the FA's plan to define and control scope. The two main areas of scope control are the maintenance and approval of a Project Work Plan and Schedule and a Requirements Management Plan.

The Project Work Plan and Schedule includes a Work Breakdown Structure (WBS) based upon deliverables and milestones of the project. The WBS organizes and defines the total scope of the project work. Low level WBS work packages allow the scope to be scheduled, monitored, cost estimated, and controlled.

Project Time Management

Project Time Management includes activities related to managing the schedule of the project, such as the FA's approach to schedule definition, approval, and control. It also includes providing information on schedule performance to the project stakeholders. A Schedule Management Plan will include the tools used by the FA to manage and control the Project Work Plan. As updates to the Project Work Plan are required 30 days prior to the start of each project phase, the Schedule Management Plan must address how these updates will be completed and presented to the State.

Schedule control is also a portion of the Integrated Change Management Process. The Schedule Management Plan will define the criteria for when a schedule change initiates a Change Control item.

Project Cost Management

Project Cost Management includes the processes involved in planning, executing, budgeting and controlling costs so that the project can be completed within the approved budget. The FA will include a Cost Management Plan in the PMP which will be their methodology to managing and controlling the overall project cost. The Cost Management Plan will also include how the FA will approach cost estimating and cost control for ongoing changes through the Integrated Change Management process.

Project Quality Management

Project Quality Management involves Quality Planning, Quality Assurance and Quality Control. The PMP will include the FA's Quality Management Plan. The Quality Management Plan will include the FA's methodology to Quality Management and the following components:

- Quality Planning – How the FA plans to work with the State to define quality standards that are relevant to the project and how to satisfy them. Quality metrics, quality checklists, and process improvement plans are all components of Quality Planning.
- Quality Assurance – How the FA plans to apply the quality activities to ensure the overall project will employ all processes needed to meet requirements.
- Quality Control – How the FA will monitor and report on specific project results to determine whether they comply with quality standards defined. Results of Quality Control are fed back to the Quality Assurance process to re-evaluate and analyze the quality standards.

In addition to the overall methodology for addressing Quality Assurance and Quality Control, the Quality Management Plan must also include the FA's Test Plan. The Test Plan will include the FA's methodology for testing in each phase of the project and will include their approach:

- Unit Test – Includes tests to ensure that changes meet the intended purpose, do not cause unintended consequences, and do not cause system errors upon execution of changed programs, batches, pages, or procedures.
- System Test – Includes test scenarios or use cases with anticipated outcome for each scenario.
- Volume or Performance Test – Includes tests for production based on estimates of transaction volumes.

- User Acceptance Test – Includes a set of disciplined tests developed by the FA and/or EOHHS that validates/shows that all functionality of the system is operating correctly (for example, screen display is correct, edits are working correctly, correct data is being used to populate fields).
- Operations Readiness Test – Includes demonstrations of system processing through all steps, load testing and results, staff readiness testing, and communications testing.
- Regression Test – Any type of software testing that seeks to uncover software regressions where previously working software functionality stops working as intended. Typically, regressions occur as an unintended consequence of program changes. Regression should occur throughout all phases of the project in conjunction with other types of testing.

Project Human Resources Management

Project Human Resource Management includes all the processes that are used to organize and manage the project team. The PMP will include the FA's methodology to Human Resource Management in the Staffing Plan. The Staffing Plan will include the FA's approach for addressing staffing requirements, project roles and responsibilities and how changes in staffing will be handled. Detailed project staffing requirements are included in this RFP at Section 5.1: Project Initiation and Start-up Activities.

Project Communications Management

Project Communications Management involves all the processes required to ensure timely and appropriate collection and distribution of project information. The PMP will include the FA's Communications Management Plan. The FA will include its methodology for determining the information needs of project stakeholders, how needed information will be made available to stakeholders in a timely manner, and how performance reporting will be distributed to ensure successful project communication to all levels of stakeholders.

The Monthly Status Reports described in Project Time Management are also a key component to Project Communications Management and the Communications Management Plan.

Project Risk Management

Project Risk Management includes all the processes concerned with conducting risk management planning, identification, analysis, responses and monitoring, and control on a project. The objective of Risk Management is to increase the impact of positive events and decrease the impact and probability of adverse events on the project. The PMP will include the FA's Risk Management Plan. The Risk Management Plan will include the FA's methodology for risk planning, identification, analysis, response planning and monitoring, and controlling project risks. The FA will also include how they plan to track and report on project risks.

Project issues are risks that have come to fruition. Once a project risk has occurred, it becomes an issue. The FA's Risk Management Plan will also address issue management including tracking, impact analysis, mitigation plans and escalation procedures.

Project Procurement Management

Project Procurement Management includes all the processes to purchase or acquire the products and services from out FA's project team to meet requirements. The PMP will include the FA's Procurement Management Plan that addresses any hardware and software that must be purchased. The resources and tasks to accomplish this will be included in the Project Work Plan and Schedule for Transition activities.

5.2.2. Deliverables

The FA will prepare the following deliverables in support of Project Management activities:

- Project Management Plan, including:
 - o Change Management Plan;
 - o Project Work Plan and Schedule;
 - o Requirements Management Plan, including methodology for:
 - Requirements Analysis and Joint Application Design (JAD) sessions for the Enhancement activities
 - Detailed Requirements Documentation and Approval
 - Completion of a Requirements Traceability Matrix; and
 - Completion of a Requirements Gap Analysis and Corrective Action Plan (CAP);
 - o Schedule Management Plan;
 - o Monthly Status Reports, including:
 - Summary of the work completed during the previous month and any results achieved (by deliverable, milestone, and relevant work breakdown elements);
 - Updated Project Work Plan and Schedule;
 - Schedule for delivery of the next version of the PMP;
 - Summary of the proposed tasks and deliverables to be performed for the upcoming month;
 - FA's analysis of critical issues, including any schedule slippage;
 - Risk tracking and assessment, with mitigation strategies;

- Documentation of issue management and change management along with recommended corrective action;
 - A dashboard summary that tabulates data for performance and work remaining on the project, broken down by deliverable and milestone; and
 - The Schedule Performance Index, the ratio of Earned Value, and Planned Value for the total Design Development Implementation (DDI) phase and each active DDI life cycle phase;
- o Cost Management Plan;
 - o Quality Management Plan;
 - o Test Plan;
 - o Staffing Plan;
 - o Communications Management Plan;
 - o Risk Management Plan; and
 - o Procurement Management Plan.

5.2.3. **Fiscal Agent Responsibilities**

The FA will support Project Management activities as follows:

- Provide in the Technical Proposal a preliminary Project Work Plan and Schedule as required by Section 4.2.9 of this RFP;
- Provide a baseline version of the Project Work Plan and Schedule, as part of the overall PMP, within 30 days of the conclusion of contract negotiations and:
 - o Maintain throughout the project;
 - o Update monthly;
 - o Include detailed activities and dates at the beginning of each project phase; and
 - o Align changes to the Project Work Plan and Schedule with the approved Change Management Plan, as each revision or update of the work plan is considered a re-baselining of the project schedule;
- Implement test environments that support all testing requirements including a UAT environment. The State requires that the UAT environment shall contain the FA's system-tested version of all MMIS software. Software shall be migrated to the UAT environment only after the State signs-off of system test results. Software shall be migrated to production from the UAT environment only after the State approves the acceptance test results;

- Create and submit for approval by EOHHS of a Deliverable Expectation Document (DED) for all required and proposed deliverables. The DED shall outline the content and scope of the deliverable as well as clearly defined acceptance criteria. The DED must be delivered to EOHHS when work by the FA begins on the deliverable, but not less than 30 days before the deliverable due date. In addition:
 - o Submit deliverables to the EOHHS by the due dates as provided in the DED for that deliverable;
 - o Provide all document deliverables in a Microsoft Office format unless otherwise approved by the State. The version of Microsoft Office shall be the same as the version used by the State's Project Office and the software versions shall be compatible with the State's software;
 - o Use delivery media for deliverables that is compatible with storage devices as approved by the EOHHS
 - o Use a delivery method for deliverables that is subject to approval of the EOHHS;
 - o Submit all deliverables for Acceptance to EOHHS. The deliverable shall be evaluated for Acceptance by determining its compliance with contracts and DED requirements, objectives, testing criteria, and acceptance criteria:
 - If a deliverable is rejected, correct the deliverable and re-present it to the EOHHS within five (5) business days;
 - If the modification needs longer than five (5) business days or at the State's request, provide a CAP within five (5) business days of receiving the rejection memo. EOHHS shall review the CAP, and if the Plan is Accepted, execute the plan and conduct another Deliverable review at the end of that process;
 - o Reflect revisions to the deliverable required by the State within five (5) business days of receiving written notification of the changes. The State may, at its discretion, allow a period longer than five (5) business days in consideration of the impact of the revised requirements by providing written notification to the FA;
 - o Assume that deliverable reviews shall be held concurrently with other scheduled activities, as EOHHS recognizes that the review times required could severely impact any project plan;
 - o Initiate the next phase of the project, unless otherwise directed by EOHHS, during the periods of deliverable review prior to milestone reviews; and

- o Mark any recurring deliverable that has not been changed since last delivered as "No Update Required" so that the State may further expedite the acceptance process;
- Provide materials for IV&V review and participate in discussions with IV&V Contractors and EOHHS to ensure IV&V activities can be completed; and
- Coordinate activities with the Project Management Office contractor as required by EOHHS.

5.2.4. State Responsibilities

The State will support Project Management activities as follows:

- Notify the FA Project Manager in writing if the acceptance process for specific recurring deliverables has been suspended and if the FA shall assume that those specific deliverables have been accepted when received by the State;
- Notify the FA Project Manager in writing if there is a resumption of the acceptance;
- Use the services of an IV&V Contractor to assist in Transition and Enhancement activities. The IV&V Contractor will report to EOHHS and will be tasked with tracking the FA's adherence to the Seven Conditions and Standards contained in CMS Medicaid IT Supplement (MITS-11-01-v1.0) released in April 2011 as it completes the Enhancement activities; and
- Use the services of a PMO FA for the Transition, Enhancement and Certification activities. The PMO and FA will report to EOHHS and will be responsible for maintaining a consolidated Project Management plan and schedule that incorporates the tasks and activities of the FA, the IV&V Contractor and EOHHS.

5.3. Transition Activities

Transition activities consist of the activities required to transfer the operation of Rhode Island's MMIS and its supporting programs from the current FA to the new FA. It is the intention of EOHHS to allow Bidders maximum flexibility in hosting of the MMIS and peripheral systems. Both incumbent and new Bidders may propose a hosting solution and transition plan to that new solution that best meets the needs of the State.

Transition activities begin on the Contract start date and end on the Start of Operations by the new FA. If the incumbent FA is the Successful Bidder, some Transition activities may not be required if the incumbent proposes the current hosting environment as best meeting the needs of the State.

The FA is responsible for leading and performing all Transition activities. The State and the incumbent FA will support the Transition activities as necessary, but the transition is a core function of assuming the FA role. Therefore, it is the

intention of the State that the FA owns this function. In the event the incumbent FA is the Successful Bidder, some of the Transition activities may not be applicable. This RFP does not preclude the incumbent FA from proposing a hosting solution that is different than what is currently in place. The State will evaluate all responses based on best alignment with EOHHS' architectural strategy and needs.

The major Transition activities include:

- Transition planning activities to assess the current MMIS functions, system requirements, processes, and risks and build the necessary plans to guide the Transition activities (applies to the new FA and may also apply to incumbent);
- Installation of the Core MMIS and any existing peripheral systems on the new FA's hardware (applies to new FA and may also apply to incumbent);
- Modification of the system software to run in the new environment (applies to new FA and may also apply to incumbent);
- System testing, including unit testing, structured testing, and user acceptance testing (applies to new FA and may also apply to incumbent);
- Parallel testing between the current system and the newly installed transferred Core MMIS and existing peripheral system tools (applies to new FA and may also apply to incumbent);
- Transition of Medicaid Claims Processing and Support services (new FA only); and
- Implementation and cutover (applies to new FA and may also apply to incumbent).

Transition activities apply to the operation of the MMIS and its existing peripheral systems, as described in the Bidder's Library.

To minimize risks and maximize efficiencies, the FA must use a proven methodology to complete the Transition activities. The FA must document its approach in the updated PMP delivered prior to the start of the Transition activities.

EOHHS seeks FAs to propose a proven transition methodology that meets the following goals:

- Minimize risks to current MMIS operations during the Transition period;
- Minimize Transition timeframes;
- Ensure data integrity and minimize data loss;
- Ensure data protection and confidentiality during the Transition period; and
- Ensure seamless transition of operational activities between the FA, State, intermediaries, providers, and recipients.

5.3.1. Planning

Transition planning activities focus on assessing the current MMIS functions, system requirements, processes, and risks and build the necessary plans to guide the Transition activities (applies to new FA and may also apply to incumbent).

Deliverables

The FA will prepare the following deliverables in support of Transition planning activities:

- Transition Plan:
 - o The Transition Plan must include at a minimum: strategy, method, tasks and milestones, resources and responsibilities, schedule, requirements for support from the existing MMIS FA, tasks, milestones, and any new required interfaces; and
- Informal presentation to EOHHS staff, which should describe the Transition Plan, the procedures used by the FA to gather the information needed to prepare the Transition Plan.

Fiscal Agent Responsibilities

The FA will support Transition planning activities as follows:

- Work with the EOHHS, the State, and the Incumbent FA to identify all information required to develop a detailed Transition Plan;
- Develop a proposed Transition Plan that addresses the reduction of risk during transition of the MMIS and all applicable systems. EOHHS will authorize final dates for the implementation of the MMIS, based on dates in the approved Project Work Plan and Schedule;
- Conduct the Transition activities without interruption or delays in all current MMIS operations, including provider enrollment and claims payment. Implementation of the MMIS operations shall not disrupt State and federal reporting activities; and
- Identify the location where it will perform each MMIS-related and FA service functions. EOHHS requires that the FA maintain a facility as described in Section 5.1 of this RFP.

State Responsibilities

The State will support Transition planning activities as follows:

- Meet with the FA to discuss the Transition Plan, strategy, and timelines;
- Coordinate and act as a liaison with the incumbent FA (as necessary);
- Approve the content and format of all deliverables at the outset of the Transition activities; and

- Approve each and every activity before it occurs. EOHHS reserves the right to reject any deliverable that is not in the proper format or does not appear to completely address the function of the deliverable requirement.

5.3.2. System Installation

The State wishes to explore cloud based computing hosting models where the infrastructure, including hardware, data center facilities, and network components are provided by the FA as a comprehensive hosting solution service. It is the intention of this RFP for Bidders to propose innovative methods to host the State's MMIS, leveraging Bidder's investments in highly redundant, scalable, secure, and high performance hosting platforms and world class data centers. The State's perspective is that by leveraging these investments and using slices of larger systems, it will represent an overall long term cost savings to the State as compared to more conventional hosting methods where the State owns the hardware and infrastructure.

The State wishes Bidders to propose innovative hosting and hardware options that meet the following goals:

- Provide like or better performance, stability, and capacity than the current MMIS;
- Provide for all current system functionality for the core MMIS and supporting applications hosted by the FA;
- Provide a rigorous technology refresh plan that ensures the hosting platform remains current and supported by hardware manufacturers;
- Provide mature data center technology support processes that will meet the SLAs defined in Appendix J to this RFP; and
- Provide system, data, and physical security that meet or exceeds current security controls.

The current hosting environment is described in detail in the Bidder's Library.

The requirements for the hosting environment are included in Appendix O.6 to this RFP. Bidders must complete the checklists and include them in the proposal.

Deliverables

The FA will prepare the following deliverables in support of System Installation activities:

- Updated PMP to support the Installation activities;
- Detailed Design Documentation (DD) of the Transition MMIS system;
- Requirements Traceability Matrix;
- System Security Plan;

- Build out of the Transition MMIS; and
- As-built documentation.

Fiscal Agent Responsibilities

The DD shall identify how and where the System documented requirements are met in the design. At a minimum, the DD must be available in hardcopy and in an electronic media and format compatible with EOHHS standards, and must include:

- A systems standards manual, listing all standards, practices, and conventions, such as, language, special software, identification of all test and production libraries, and qualitative aspects of data modeling and design;
- An identification of system files and processing architecture;
- A general narrative of the entire system and the flow of data through the system;
- A general narrative of each business function, describing business functions, features, and processes;
- A flow diagram of each business function, identifying all major inputs, processes, and outputs of the business function;
- Lists of all inputs and outputs, by business function;
- A listing and brief description of each file;
- Preliminary screen and report layouts;
- High and medium level batch flowcharts to the job, procedure, and program level;
- A logical data model;
- A high-level data model and detailed and physically specific data models;
- Entity relation diagrams;
- Preliminary screen and report narrative descriptions; and
- Final network configuration with graphic layout of all network lines, switches, and all hardware/software detail.

The FA shall implement a Requirements Traceability Matrix (RTM) for all System requirements. The implementation of the RTM shall be accomplished with a tool contained in the FA's proposed solution. The RTM must have the following characteristics:

- Associates all project artifacts (design and test documentation) associated with each requirement;

- Tracks impacts to project artifacts when a requirement change takes place; and
- Produces reports for specific trace elements, including but not limited to:
 - o Requirement to DD;
 - o Requirement to Test Case;
 - o Requirement to Test Results;
 - o Unsatisfied or unallocated requirements; and
 - o Requirements associated with Change Orders.

The FA must revise the Detailed System Design to reflect changes identified during the development and testing process. It must provide updated pages reflecting the design of the system as it was built to EOHHS for review and approval. The As-built documentation will include:

- All selected configuration items configured during installation;
- Applicable screenshots that support the installation steps;
- Reference for all software license keys used to support the installation; and
- Any and all service accounts, super user accounts, administrative accounts used for installation.

The FA will develop a System Security Plan that identifies all current system risks and controls in place to mitigate those risks. The System Security Plan shall be based on the National Institute of Standards and Technology (NIST) Special Publication 800-53, rev.3. The FA will be required adherence to federal security guidelines for systems that meet Federal Information Processing Standards 199 MEDIUM level or above security thresholds. The System Security Plan shall include the following control areas:

- Access Control
- Awareness and Training
- Audit and Accountability
- Security Assessment and Authorization
- Configuration Management
- Contingency Planning
- Identification and Authentication
- Incident Response
- Maintenance
- Media Protection
- Physical and Environmental Protection

- Planning
- Personnel Security
- Risk Assessment
- System and Services Acquisition
- System and Communications Protection
- System and Information Integrity I
- Program Management

State Responsibilities

The State will support System Installation activities as follows:

- Meet with the FA to discuss the proposed design, security plan, and system requirements ;
- Review all Transition MMIS system designs and documentation;
- Review each Installation deliverable outlined within the updated Project Work Plan and Schedule addressing the installation tasks. EOHHS will either notify the FA of acceptance or provide the FA a detailed list of deficiencies that must be remedied; and
- Sign off on System Installation deliverables.

5.3.3. System Testing

Transition System Testing activities focus on System testing, including unit testing, structured testing, and UAT (applies to new FA and may also apply to incumbent); and parallel testing between the current system and the newly installed transferred Core MMIS and existing peripheral system tools (applies to new FA and may also apply to incumbent).

Deliverables

The FA will prepare the following deliverables in support of Transition System testing activities:

- Design, set up, documentation, and validation of a Test Environment and related processes and procedures;
- Develop Unit testing plans and schedule;
- Develop structured testing plans and schedule, including, parallel tests, load tests, data tests, and retests of failed items;
- Develop UAT plans and schedule;
- Conduct all necessary tests included in all testing plans;
- Support all IV&V testing activities as required;

- Presentation of unit test results to EOHHS;
- Presentation of structured test results to EOHHS; and
- Presentation of UAT results to EOHHS.

Fiscal Agent Responsibilities

The FA will support Transition System testing activities as follows:

- Complete system testing to validate the proper operations of the MMIS and associated support programs must be accomplished, in accordance with IEEE 1012-2004 Standard for Software Verification and Validation;
- Implement one or more Testing Environments that meets the following minimal requirements:
 - o A complete, functioning copy of the MMIS software, peripheral components, and the software to support the transition. The Test Environment will require acceptance by EOHHS;
 - o A separate system region dedicated specifically to the Rhode Island software and data (a logical partition may be utilized) and separate from any Development, User Acceptance Testing, or Production environments;
 - o Security controls that are commensurable with the MMIS Production environment with security controls and processes that provide the same level of security as Production;
 - o The ability to manage changes through the Change Management, Release Management and Configuration Management Processes as defined in Section 5.2 of this RFP; and
 - o Support performance and load testing that match current production capabilities;
- Include specific procedures and tools for backing up, restoring, and refreshing all test data to realign the test environment with production on a regular basis:
 - o Migration procedures describing the steps needed to move or copy software from Development to the Test Environment; and
 - o Migration procedures describing the steps needed to move or copy software from the Test Environment to Production;
- Allow UAT to occur without interfering with unit level or system level testing;
- Create and deliver to EOHHS, comprehensive and thorough Transition Testing Plans. These testing plans must incorporate unit testing, structured testing, and initial UAT;

- Revise and retest as often as necessary to meet EOHHS requirements, as EOHHS will not approve the MMIS and its supporting programs for implementation until all tests pass to the satisfaction of EOHHS;
- Provide all documentation for the software being tested before UAT will begin. In the event that EOHHS notifies the FA of deficiencies, the FA must correct the deficiencies within five (5) working days, unless EOHHS consents in writing to a different timetable;
- Participate in the UAT of the system by providing technical staff at EOHHS' location to assist in demonstrating all functions of the system. In the event that one or more applications supplied by the FA are not accepted, the FA must correct the deficiencies or provide, at its own expense, software that may be required to meet the acceptance criteria within 10 calendar days or a mutually agreed upon period; and
- Demonstrate completeness of the transition of the baseline system during the parallel testing task. The outputs produced by the transition FA will be consistent with the outputs produced by the current MMIS. Additional outputs may also be required when enhancements are implemented.

State Responsibilities

The State will support Transition System testing activities as follows:

- Provide State staff to facilitate UAT as applicable (for State ran functions);
- Review all test results, with a special focus on structured data tests, UAT, parallel tests, and retests of failed items;
- Review each test deliverable outlined within the updated Project Work Plan and Schedule addressing the testing tasks. EOHHS will either notify the FA of acceptance or provide the FA a detailed list of deficiencies that must be remedied;
- Upon notification by the FA that the MMIS has been fully implemented and is ready for UAT, evaluate and test the systems within 30 days to confirm that they perform without any defects and perform pursuant to the specifications set forth in this RFP; and
- Sign off on each MMIS function to ensure that the use meets all functional and technical requirements.

5.3.4. Operational Readiness

The Operational Readiness tests are designed to ensure that the FA and EOHHS staff are ready to process all inputs, correctly generate outputs, meet all reporting requirements, utilize a properly functioning data communications network, and have a demonstrated backup capacity. The FA also must assess the operational readiness of EOHHS staff that performs all business functions and operations. Operational Readiness testing must include demonstrations, load testing and results, staff readiness testing, and communications testing.

An additional component of the Operational Readiness Test is the demonstration and verification of data security and 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.

Deliverables

The FA will prepare the following deliverables in support of Transition Operational Readiness activities:

- Revised operating procedures
- Training plan
- Work plan
- Status reports
- Report distribution schedule
- Test plans and schedules
- Operational Readiness Test Plans
- Updated Project Work Plan and Schedule
- Updated staffing plan for operations
- Operational testing results
- Disaster Recovery Plan
- Initial operational readiness assessment and presentation to EOHHS
- Final operational readiness assessment and presentation to EOHHS

Fiscal Agent Responsibilities

The FA will support Transition Operational Readiness activities as follows:

- Establish all test plans to be approved by EOHHS;
- Develop procedures and supporting documentation for testing;
- Establish test schedules with EOHHS staff;
- Install the most recent versions of the MMIS and its supporting programs, including, but not limited to, all batch and online programs, telecommunications, data entry software, and test files and replacements for licensed software and systems as described throughout this document;
- Conduct operational readiness tests, including:

- o A volume test of several days of production capacity claim record volumes to demonstrate the MMIS and the FA's staff is prepared for full production;
- o A pilot test of actual claims processing in a full operational environment starting with the submission of Electronic Data Interchange (EDI) transactions into the translator through the payment process, including, but not limited to, document imaging, check request, issuance, and check/remittance advice mailing process (both electronically and on paper); and
- o All operational functions including, but not be limited to:
 - Enrollment and eligibility processes, such as notices, member demographic changes and capitation processing; and
 - The addition, deletion and updating of enrollment records testing will include, but not be limited to, a member change of address, and the addition of a new member;
- Assess the operational readiness of EOHHS staff that performs all business functions and operations;
- Demonstrate and verify data security and disaster prevention and recovery procedures;
- Perform specific implementation and operations functions to ensure operational readiness;
- Perform final file conversions if needed, recruit and train operations staff, and conduct any necessary training to providers and EOHHS staff and their designees;
- Coordinate with EOHHS to resolve problems encountered during the installation of the MMIS onto new hardware, if any issues develop as a result of the Operational Readiness Tests;
- Conduct a formal readiness walkthrough with EOHHS, to prove that all functional areas are ready;
- Identify and resolve problems and discrepancies with EOHHS or EOHHS business partners;
- Analyze and record test results;
- Identify, generate, and provide test data as needed and in necessary to complete the test plans;
- Perform tests of reports from prior-cycle data to compare to existing reports for data integrity of the modified or enhanced system;

- Resolve defects in the MMIS identified as a result of testing. If any defect is not corrected before the system goes into production, monitor it until resolved;
- Conduct comprehensive system testing for all functional areas to ensure that the MMIS is processing correctly, prior to implementation of new FA operations. Testing will be conducted using applicable input files as specified by EOHHS;
- Process, from claims receipt to final disposition through the payment request process, in a fully operational environment, a representative sample of actual or test claim records, as designated by EOHHS, as an Operational Readiness Test;
- Process, from receipt of eligibility update records to final disposition through the enrollment process, in a fully operational environment, a representative sample of actual or test enrollment records, as designated by EOHHS, as an Operational Readiness Test;
- Prepare a final Operational Readiness Assessment document, including results of all testing and an assessment of the final operational readiness of FA staff to operate the MMIS. The report will also certify that the MMIS, its business functions, functions, processes, operational procedures, staffing, telecommunications, and all other associated support is in place and ready for operation;
- Revise systems and user documentation as required to fully describe system operations and any modifications resulting from the transition;
- Conduct orientation and training for EOHHS personnel on FA organization, functional responsibilities, and operational procedures;
- Make arrangements for the acceptance of all claim-related receipts and pending claims from the Incumbent FA for completion of processing after transition;
- Work with Incumbent FA to stop acceptance of any new claims, either electronic or hard copies, during the final five working days prior to the FA transition date;
- Allow for the complete resolution of all edits and adjudication of claims by the current FA;
- Identify and report any implementation issues to EOHHS
- Identify necessary modifications to manual and automated operating procedures. Revise operating procedures as required;
- Make arrangements for the acceptance of all enrollment related records (e.g., benefit category change, address update, premium payment) from the Incumbent FA for completion of processing after transition;

- Work with Incumbent FA to stop acceptance of any new enrollment or eligibility additions, deletions or updates during the final five working days prior to the transfer date; and
- Perform a member reconciliation process with Incumbent FA's records to verify the accuracy of enrollment and eligibility data after lock-down of enrollment and eligibility related activity.

State Responsibilities

The State will support Transition System Testing activities as follows:

- Provide State staff to Operation Readiness Testing as applicable;
- Review all Operational Readiness Testing results;
- Review each test deliverable outlined within the updated Project Work Plan Schedule addressing the testing tasks. EOHHS will either notify the FA of acceptance or provide the FA a detailed list of deficiencies that must be remedied;
- Sign off on Operational Readiness Tests signaling State acceptance that the System is ready for Operation; and
- Review and approve or require revisions to the final Operational Readiness Assessment.

5.3.5. Operations

The FA shall perform specific implementation activities during the transition, as detailed in the following subsections. The FA must implement a fully operational MMIS on January 1, 2013, or a date to be approved by EOHHS. The FA will receive and be responsible for processing claims received after December 1, 2012, or a date to be approved by EOHHS.

Fully operational is defined as processing correctly all claim types, including all claims adjustments and mass adjustments, and other financial transactions; maintaining all system files; providing access to all supporting components, including all existing business functions; producing all required reports; meeting all system requirements; and performing all other FA responsibilities specified in this contract. If EOHHS determines the system will not be operational on December 1, 2012 or the date approved in the final Contract, then implementation readiness assessments will be made until such time as EOHHS determines the system is either fully operational or that the FA shall be deemed in default.

Deliverables

The FA will prepare the following deliverables in support of Transition Operations activities:

- Assumption of operations responsibilities;

- Initial assessment of implementation success and presentation to EOHHS;
- Assessment of implementation success and presentation to EOHHS;
- Final Operational Readiness Assessment to assure the ability of the FA to operate the MMIS according to the requirements specified in the contract;
- Training for EOHHS staff;
- File reconciliation with the records of the Incumbent FA to verify accurateness of all transfer of data after lock-down of related functional area activities, such as eligibility, enrollment, claims, premiums, and TPL;
- Results of file reconciliation to EOHHS staff;
- Transfer of all data and files to the new FA;
- Identification and documentation of any implementation issues to EOHHS, and placement of information online in the documentation repository;
- Documentation of resolution for outstanding issues; and
- Completion transition, which is due no later than December 1, 2012 or a date to be approved by EOHHS.

Fiscal Agent Responsibilities

The FA will support Transition Operations activities as follows:

- Coordinate with the Incumbent FA on questions and problems relating to implementation and testing;
- Conduct orientation and training for EOHHS personnel on FA organization, functional responsibilities, and operational procedures;
- Implement operational plan;
- Allow for the complete resolution of all outstanding issues, (e.g., edits and adjudication of claims) by the Incumbent FA to be transferred;
- Conduct weekly status meetings with the MMIS project manager and other EOHHS staff and post meeting minutes online in the documentation repository, if appropriate;
- Determine status of MMIS according to transition plan, and identify and report to EOHHS any implementation features that are behind schedule according to the Transition Plan;
- Prepare and submit to EOHHS for review, CAP for deficiencies within three business days of identification;
- Implement EOHHS approved CAPs within agreed-upon time frames;
- Make arrangements for the acceptance of all enrollment related records (e.g., benefit category change, address update, premium payment) from the current FA for completion of processing after transition;

- Include in the plan that the Incumbent FA will stop accepting new enrollment or eligibility additions, deletions, or updates during the final five working days prior to the transfer date:
 - o Accept all current files from EOHHS and the Incumbent FA. FA files may be magnetic tape, CD, or paper;
 - o Accept and arrange for storage and backup of archive files transferred on computer-readable media. The storage of archive files shall be maintained in an offsite vault that is water- and fire-resistant, as specified in the FA's proposal. The files shall be maintained using archival-quality media that are retrievable by the FAI
 - o Balance files to EOHHS's and Incumbent FA's control totals;
 - o Print and distribute all Rhode Island-unique claim forms;
 - o Conduct provider re-enrollment or certification, as directed by EOHHS;
 - o Accept claim records for processing by providers and EOHHS; and
 - o Begin processing all claim types;
- Transition the current MMIS and its associated programs to its own hardware, installing all software and the telecommunications networks required to operate the system according to the specifications outlined in the current system documentation and the Contract;
- Transfer or develop any software necessary to perform its operational responsibilities (e.g., data entry, claims control, electronic claims submission software);
- Develop, prepare, print, maintain, produce, and distribute MMIS documentation, MMIS user manuals and provider manuals;
- Prepare and print all revisions, in final form, for all changes, corrections, or enhancements to the system and/or medical assistance program, prior to EOHHS sign off on the system change;
- Draft provider specific billing instructions as well as general billing instructions that are used by all provider types for the provider manuals and the EVS (eligibility verification system);
- Produce and distribute all MMIS user manual and EOHHS provider manual updates during the term of this contract. Distribution of EOHHS provider manuals will be to all providers enrolled in Medicaid programs, State staff, and any agency, organization, and/or person specified by EOHHS. All manuals must be available in electronic format that is compatible with EOHHS standards;
- Provide MMIS user manuals in electronic form as a part of an online help facility, which will provide complete and up-to-date information concerning

access to all MMIS functions as well as system, navigation, printing, and reporting information;

- Develop and provide complete, accurate, and timely documentation of the MMIS. One hard copy and one electronic copy of the MMIS documentation must be provided within 30 days following EOHHS acceptance of the MMIS at the close of the Transition Activities. EOHHS acceptance will not be given and the final system documentation cannot be delivered if portions of the MMIS are not functioning properly;
- Provide updates to the one paper copy and an electronic copy, in a format that is compatible with EOHHS standards, of the MMIS documentation within 20 days following EOHHS acceptance of the change and prior to EOHHS sign off on the completion of the system change;
- Provide all equipment and software necessary for it to successfully transition, test, implement, operate, and maintain the MMIS;
- Be responsible for site preparation for its local project office, including supplying all hardware and software to connect to the State of Rhode Island LAN and WAN (Statewide area network);
- Supply the necessary equipment and software that will be required by the MMIS users beyond their standard configuration;
- Provide access to MMIS tables/files via telecommunications links. All equipment and network hardware and software required to interface with State systems must meet ISD telecommunications and interface standards; and
- Provide telecommunications technical support through a help desk, for such issues as troubleshooting, device resets, and network problems.

State Responsibilities

The State will support Transition Operations activities as follows:

- Review and approve assessment from FA that the system is operations ready;
- Oversee final transfer of all data, including, but not limited to, eligibility and claims data;
- Review and approve the FA's notification process and content to inform providers of the new MMIS contract, new billing procedures, and the date from which all claim records are to be submitted to the new FA;
- Provide staff time to attend training sessions conducted by the FA for EOHHS personnel;
- Coordinate the termination or assumption of leases of MMIS hardware and software;

- Ensure that business associates terminate communications with Incumbent FA, and recommence with new FA, such as print Contractors, data exchange contacts;
- Work with Incumbent FA on remaining Transition activities;
- Work with FA to establish CAPs if implementation or re-procurement activities fall behind schedule or fail; and
- Provide all policy updates to MMIS documentation, MMIS user manuals, and provider manuals.

5.4. Maintenance and Operations Activities

Maintenance and Operations activities will begin upon State approval of the completion of Transition activities and the Start of Operations. An updated version of the PMP must be delivered 30 days prior to the start of Maintenance and Operations. Maintenance and Operations consists of three major activities:

- Operations – Operations activities are those that support the day-to-day maintenance and operations of the MMIS applications and related systems. Operations activities include maintenance of the hardware and software platform on which the applications reside. During this activity the MMIS FA is required to provide services to the State users, Medicaid members and providers.
- Maintenance – Maintenance activities are those necessary to maintain the MMIS and correct software defects in the MMIS and related applications.
- Modification – Modification activities are those necessary to make changes to the application systems based on Change Requests issued within the Change Management process. Modifications are required to support the ongoing management of the program and remain in compliance with federal and State regulations and policies.

5.4.1. MMIS Operations

The FA will be responsible for the operation of the MMIS and related systems. EOHHS requires that the FA provide qualified personnel, resources, facilities, and supplies to support the operation of the MMIS and related programs to meet the SLAs described in Appendix J to this RFP.

The FA will receive, and be responsible for processing, claims received at the Start of Operations or a date to be approved by EOHHS.

The new MMIS FA will be required to take over and transition current operations prior to Start of Operations. Upon the approved Start of Operations, the FA will begin processing claims and other transactions as provided under the current contract. These operations are expansive, involving programs other than Medical Assistance and agencies other than EOHHS. ***The FA is expected to perform FA responsibilities outlined in Table 22 for all current operations***

across all programs and agencies. Agencies supported by the MMIS FA include:

- EOHHS;
- DHS, including DEA;
- DOH;
- DCYF;
- BHDDH; and
- DOC.

Programs include but are not limited to:

- Medical Assistance programs approved under the 1115 Global Waiver:
 - o Rlte Care
 - o Rlte Share
 - o Rlte Smiles
 - o Rhody Health Partners
 - o Connect Care Choice
 - o PACE
 - o Expanded Home and Community Based Services
 - o Medicaid Fee-for-Service;
- Programs under Costs Not Otherwise Matchable (CNOM)s approved under the 1115 Global Waiver;
- Meals on Wheels;
- State-funded home-care benefits to eligible elderly beneficiaries
- RIPAE, including POS processing;
- Adult Day Care and Home Care;
- Breast and Cervical Cancer Treatment Program;
- Women's Cancer Screening Program;
- Children's Health Insurance Plan;
- Ryan White;
- Children with Special Health Care Needs;
- Katie Beckett;
- Community and Living Supports program;
- Rehabilitation Services;

- Transportation services for certain State-only population; and
- Corrections.

The majority of these programs are described to some extent in documentation of interfaces, procedures, design documents and other materials contained in the Bidders' Library. The MITA SS-A provides details on the "as-is" business functions within the MITA framework (Medical Assistance). Not all details are provided for each and every program.

It is the Bidder's responsibility to review library contents and present questions or requests for additional information if needed to support its Proposal.

This section provides a description of Operations Activities, deliverables, FA and State Responsibilities.

Description of Operations Activities

Operations Activities are organized by MITA business area for ease of reference. These business areas are Operations Management, Program Management, Member Management, Provider Management, Care Management, and Program Integrity.

Table 21: Business Areas for Operations Activities

Business Area	Function	Sub-Functions
Operations Management	1. Claims Processing	a. Claims Entry b. Claims Resolution c. Clinical Claims Review
	2. Prior Authorizations	
	3. TPL	
	4. Pharmacy Management	a. Maintenance of the PDL b. Lock-In Program
	5. Drug Rebate	a. Federal Rebates b. Supplemental Rebates
Program Management	6. Financial Management	a. Children's Health Account b. Premium Billing and Collection
	7. Process Improvement Team	
	8. Quality Assurance	
	9. Reporting and Data Analysis	
Member Management	10. Dental Benefits Manager	
	11. Enrollment Broker Services for Managed Care Options for Adults with Disabilities	
	12. Other Member Services	a. Language Web Services b. Incentive Payments/

		Cards
Provider Management	13. Provider Enrollment	
	14. Provider Call Center	
	15. Provider Training and Outreach	
Care Management	16. Radiology Management	
	17. Professional Clinical Services	
Program Integrity	18. Surveillance and Review	

Operations Performance Reporting

The FA must monitor performance against the State-specified KPIs in the SLAs documented in Appendix J to this RFP. SLAs address:

- System Availability;
- System Performance;
- Database Updates;
- Operational Problem Management;
- Customer Service Support;
- Claims Adjudication;
- Claims Payment;
- Reporting; and
- Drug Rebate.

The FA will develop reports to demonstrate compliance with applicable KPIs. The FA will submit a monthly Performance Report Card monthly on all KPIs, regarding the prior month's performance, no later than the 10th of the month. The report may include additional information regarding SLA compliance. Upon request, the FA will provide the State with all reports and data used in the determination of SLA compliance and calculation of KPI metrics.

If a KPI is not met, the FA must provide notice to the State and include a written CAP that describes:

- The missed KPI
- Full description of the issue
- Cause of the problem
- Risks related to the issue
- The resolution, including any failed solutions implemented prior to resolution

- Proposed corrective action going forward to avoid missing the KPI in the future

Upon receipt of the report, the State may request a follow-up meeting to discuss the issues and corrective actions. The FA will implement the plan once approved by the State.

Prior to Start of Operations, the State and the FA will review all KPIs to determine if revisions are needed. Similar reviews will be held annually, upon the implementation of a change that impacts existing KPIs, or at the request of the State.

The State and the FA agree that failure by the FA to perform in accordance with established KPIs results in a loss to the State. If the FA fails to meet the KPIs, the State may retain a percentage of the total monthly administrative fee as identified in the appendix for each SLA. Retained amounts will be deducted from monthly payments for MMIS Systems Costs approved by the State.

Deliverables

The FA will prepare the following deliverable in support of Operations activities:

- Monthly Report Card showing actual versus required performance on all SLAs;
- CAPs for correction of any missed KPIs;
- Supporting reports and data on the Monthly Report Card, as requested by the State; and
- CAPs approved by the State.

Fiscal Agent Responsibilities

The FA will be responsible for providing the following FA Services to support the Operations of the Rhode Island Medical Assistance program and all other programs currently served by the MMIS FA. The FA must staff sufficiently to achieve the KPIs and SLAs defined in Appendix J to this RFP.

FA Responsibilities are provided in checklist format because Bidders are required to acknowledge takeover of responsibilities for each area in their proposals, as described in Section 4.2.9 of this RFP.

The following tables are organized according to major MITA business processes. Additional information on FA Responsibilities is included in the Bidders' Library. Bidders are responsible for requesting clarification of any responsibilities.

Current FA Responsibilities are presented in table format below. Complete checklists are included in Appendix O.7 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 22: Fiscal Agent Responsibilities for Operations Activities

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
	Operations Management Business Area	
<i>OPS.1.0</i>	<i>Claims Processing</i>	
OPS.1.1	Pre-screen paper claims before entering into the system	☐
OPS.1.2	Return claims not meeting State approved screening criteria to providers	☐
OPS.1.3	Establish claims control balancing processes	☐
OPS.1.4	Perform claims reconciliation between claim receipts and batch processing input	☐
OPS.1.5	Enter data from paper claims into the MMIS claims processing system that are not accepted during scanning	☐
OPS.1.6	Perform exceptional adjudication of claim edits and audits in accordance with State approved guidelines (e.g., deny, override)	☐
OPS.1.6.1	Resolve suspended claims for all Medical Assistance programs as well as certain medical claims for other agency programs designated by EOHHS, including BHDDH, DHS and DEA, DOC, DOH and DCYF programs	☐
OPS.1.6.2	Support claims processing for CNOMs, which are non-Medicaid Services that receive FFP for those services designated by EOHHS. Agencies administering the 21 CNOMs include DHS, DEA, DOH, DCYF and BHDDH. A complete list of CNOMs is included in the Appendix K	☐
OPS.1.6.3	Conduct clinical review of suspended claims as necessary	☐
OPS.1.7	Perform adjudication of claims exceptions within fourteen (14) days according to State and federal billing guidelines	☐
OPS.1.8	Recommend necessary and desirable edit and audit criteria to accommodate new procedure codes, enhanced claims processing, and the implementation of new cost containment initiatives	☐
OPS.1.9	Identify and monitor operators who are authorized to force or override an edit/audit code based on individual operator IDs or authorization level	☐
OPS.1.10	Establish controls to ensure that no paper claims and attachments, tapes, or diskettes are misplaced after receipt by the contractor	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
OPS.1.11	Operate the system generated claims function of the MMIS	☐
OPS.1.12	Process all system generated claims and adjustments according to State-defined schedules and policies	☐
OPS.1.13	Operate the Medicare crossover claims function of the MMIS for all media types	☐
OPS.1.14	Report to the State any problems related to receipt of automatic crossovers and adjustments (e.g., all electronic crossovers received directly from the Medicare Intermediary or Carrier) that impact the timely processing of claims	☐
OPS.1.15	Schedule meetings/conferences with State and Medicare contractors when necessary to resolve issues related to receipt or processing of Medicare crossover claims	☐
OPS.1.16	Operate the claims/encounter pricing function of the MMIS	☐
OPS.1.17	Manually price certain claims according to State specified criteria within the timeframes defined by the State	☐
OPS.1.18	Operate the remittance advice function of the MMIS	☐
OPS.1.18.1	Produce or reproduce Remittance Advices (RAs), in hardcopy or standardized electronic format, in non-technical language that is understandable	☐
OPS.1.19	Make the 835 transaction information available to providers/vendors	☐
OPS.1.20	Operate the encounter data system function of the MMIS	☐
OPS.1.21	Provide technical assistance to MCOs as directed by the State on as needed basis	☐
OPS.1.22	Maintain and update encounter data submission manuals for MCOs	☐
OPS.1.23	Perform all claim adjustment activities according to GAAP	☐
OPS.1.24	Retain backup documentation to support mass adjustments	☐
OPS.1.25	Accommodate all State requests for system-generated adjustments	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
OPS.1.26	Process monthly DCYF claims and produce reports showing claimable amounts (claims paid) for Medicaid-eligible services	☐
<i>OPS.2.0</i>	<i>Prior Authorizations</i>	
OPS.2.1	Operate and maintain the Prior Authorization function within the MMIS	☐
OPS.2.2	Process requests for authorizations in writing from providers	☐
OPS.2.3	Provide real-time access via various methods (e.g., Web Portal, AVRS,) for PA status inquiries	☐
OPS.2.4	Enter and/or accept PA requests, approvals, etc., into the MMIS, online from authorized sources	☐
OPS.2.5	Assign unique PA control numbers and batches to PAs and accompanying documentation	☐
OPS.2.6	Generate PA approval and denial notices within two (2) business days of online entry to EOHHS and processing or according to an auto-generation distribution schedule defined by EOHHS	☐
<i>OPS.3.0</i>	<i>Third Party Liability</i>	
OPS.3.1	Perform Data Matching with health plans to identify unreported health plans, including the following:	☐
OPS.3.1.1	Establishing data match agreements with health plans in accordance with DRA requirements	☐
OPS.3.1.2	Schedule and perform data matches on a monthly basis	☐
OPS.3.1.3	Verifying match results and uploading new completely verified member health insurance information to the member TPL record in the MMIS	☐
OPS.3.1.4	Triaging all insurance leads in order to identify other members affiliated with the case and to assess the completeness of the insurance information	☐
OPS.3.2	Understand all current and new CMS regulatory requirements and implement updates/changes to ensure compliance (i.e. Deficit Reduction Act, etc.) with cost avoidance related regulations	☐
OPS.3.3	Generate and distribute quarterly State Wage Information Collection Agency (SWICA) letters from a Dept. of Labor (DOL) data match	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
OPS.3.4	Generate list of claims paid with a third party payment including Medicare where there is no client TPL and/or Medicare record	☐
OPS.3.4.1	As needed, contact insurance company to verify coverage information, i.e. policyholder information, type of coverage, dates of coverage, policy number, group number, employer information, benefits manager, dependent coverage, cost sharing obligation, etc. Update insurance information on member TPL record as applicable	☐
OPS.3.5	Tracking and reporting new lead and verification activities	☐
OPS.3.6	Generate and distribute member coordination of benefit communications	☐
OPS.3.7	Provide pay and recover activities with third parties (health plans), including the following:	☐
OPS.3.7.1	Identify and bill all pay and recover claims to liable health plans within federally mandated timeframes for retroactive periods authorized under the DRA	☐
OPS.3.7.2	Generate and distribute written communications to support pay and recover activities	☐
OPS.3.7.3	Understand all current and new CMS regulatory requirements and implement updates/changes to ensure compliance (i.e. Deficit Reduction Act, etc.) Pay and recover related regulations	☐
OPS.3.8	Track and report on performance of pay and recover activities	☐
OPS.4.0	Pharmacy Management	
OPS.4.1	Establish and staff POS Pharmacy (Provider) Help Desk	☐
OPS.4.2	Maintain and implement updates to the Preferred Drug List and State Maximum Allowable Cost (SMAC) pricing files as approved by EOHHS. The Professional Services provided for the PDL include Pharmacy and Therapeutics (P & T) Committee support including:	☐
OPS.4.2.1	Prepare and present therapeutic drug class reviews at committee meetings	☐
OPS.4.2.2	Develop recommendations for preferred drug list inclusion	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
OPS.4.2.3	Identify clinical program impacts and annual presentation of P & T program impacts	☐
OPS.4.3	Maintain and implement updates to the drug reference file as approved by EOHHS	☐
OPS.4.4	Maintain and implement updates to the J-Code/NDC crosswalk as approved by EOHHS	☐
OPS.4.5	Maintain and update drugs identified by EOHHS for the auto prior authorization process	☐
OPS.4.6	Provide direct access for the help desk staff to the provider authorization system in order to respond to real-time provider requests	☐
OPS.4.7	Administer the member lock-in program in accordance with State policies and procedures, including but not limited to the following:	☐
OPS.4.7.1	Review of recipient usage patterns to detect fraud and abuse	☐
OPS.4.7.2	Notify providers and members of their selection as a preferred/assigned lock-in provider and inform them of their responsibilities	☐
OPS.4.7.3	Receive and maintain documentation from providers for evaluating members for the lock-in program	☐
OPS.4.7.4	Maintain evidence showing reasons for Lock-in	☐
OPS.4.7.5	Assign recipient a lock-in restriction to a single prescriber and/or pharmacy	☐
OPS.4.8	Perform all Drug Utilization Review (DUR) activities in accordance with State policy and procedures	☐
OPS.5.0	Drug Rebate	
OPS.5.1	Generate and send out drug rebate invoices (including cover letter) for each labeler that has a rebate agreement signed with CMS or the State	☐
OPS.5.2	Receive and process rebate checks from labelers. Post receivables	☐
OPS.5.3	Receive, log, and process labeler disputes	☐
OPS.5.4	Perform dispute resolution, including research discrepancies by reviewing the claim-level detail, and calling Providers as necessary in regards to questionable claims	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
OPS.5.5	Maintain the drug rebate data to facilitate automatic updating with information from CMS and EOHHS	☐
OPS.5.6	Perform direct data entry of all historical data from State sources	☐
OPS.5.7	Reconcile all data sources to ensure accuracy of invoicing	☐
OPS.5.8	Maintain and update data on manufacturers with whom rebate agreements exist, including:	☐
OPS.5.8.1	Manufacturer ID numbers and labeler codes	☐
OPS.5.8.2	Indication of collection media	☐
OPS.5.8.3	Indication of invoicing media	☐
OPS.5.8.4	Contact name, mailing address, and phone numbers (voice and fax) for manufacturers	☐
OPS.5.8.5	Manufacturer (labeler) enrollment dates and termination dates	☐
OPS.5.9	Generate invoice cover letters, collection letters, and follow-up collection letters according to BMS criteria	☐
OPS.5.10	Maintain an audit trail of all correspondence, invoices, payments, and adjustments	☐
OPS.5.11	Generate manufacturer mailing labels on request	☐
OPS.5.12	Operate the Supplemental Drug Rebate Program which provides inclusion in the National Medicaid Pooling Initiative, submission of supplemental rebates, associated dispute resolution and financial program impacts. All functions performed for the Federal Drug Rebate Program are expected to be performed for the Supplemental Drug Rebate Program, as applicable	☐
	Program Management Business Area	
<i>PRM.6.0</i>	<i>Finance Management</i>	
PRM.6.1	Render Provider reimbursements promptly and correctly, in accordance with Appendix X (Service Level Agreements), specified contracts, 42 CFR Part 447.45(d) – Payment for Services, and all other requirements in this RFP (including Appendices)	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
PRM.6.2	Accept and process non-claim financial transactions (FACN) payment requests from EOHHS, at any time during the payment cycle	☐
PRM.6.3	Process FFS payments on a schedule defined by EOHHS	☐
PRM.6.4	Process capitation payments to MCO(s) and other Providers on a schedule defined by EOHHS	☐
PRM.6.5	Process requests to withhold/recoup a fixed dollar amount or a percentage of payments for any MCO or Provider from current payments	☐
PRM.6.6	Support reconciliation process by researching and resolving any discrepancies	☐
PRM.6.7	Support recoupment/refund functionality	☐
PRM.6.8	Research potential payment errors and take corrective action	☐
PRM.6.9	Generate and distribute regular payment and refund reports from the MMIS for State monitoring	☐
PRM.6.10	Generate and distribute regular payment and refund reports from the MMIS for State monitoring	☐
PRM.6.11	Generate reports of check register and provider account balances after each claims processing cycle for State review	☐
PRM.6.12	Assure the accuracy of EFTs, data transmission and data reconciliation	☐
PRM.6.13	Operate and manage the accounts receivable functions in compliance with GAAP	☐
PRM.6.14	Perform accounts receivable functions as directed by the State to include but not limited to:	☐
PRM.6.14.1	Collect overpayments	☐
PRM.6.14.2	Payments due as the result of audits and peer review findings	☐
PRM.6.14.3	Monies due from the drug rebate program	☐
PRM.6.14.4	Monies due from pay and recover activities	☐
PRM.6.15	At minimum, process the following financial transactions:	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
PRM.6.15.1	Accounts Receivables	☐
PRM.6.15.2	Recoupments	☐
PRM.6.15.3	Manual Checks	☐
PRM.6.15.4	Application of checks received to accounts receivable	☐
PRM.6.15.5	Application of checks to a payor's payment history file	☐
PRM.6.15.6	Check Stop Payment and EFT reversals	☐
PRM.6.15.6	Check Voids and void re-issue and EFT reversals	☐
PRM.6.16	Establish and maintain financial processing and adjustment processing policies and procedures and posting instructions	☐
PRM.6.17	Perform invoicing and payment collection for Rhode Island's Children's Health Account , specific functions include:	☐
PRM.6.17.1	Generate invoices to insurance companies for an amount determined by EOHHS as per a RI Statute formula. Invoicing is done annually with the exception of two carriers that are done quarterly	☐
PRM.6.17.2	Receive payments and post payments against the applicable ARs for the invoiced amounts	☐
PRM.6.17.3	Send second notice invoice if payment is not received. Notify EOHHS if second notice is not paid	☐
PRM.6.18	Provide Premium Collection professional services including a customer service team to answer inquiries from recipients on premiums invoiced, payments, coverage status, appeals, etc.	☐
PRM.6.19	Mail the Premium Collection invoices, provide lock-box services and payment processing (including credit card, debit, ACH, cash and Web payment options) and deposit payments to a State Account	☐
	Track and report Premium Collection Accounts Receivable	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
PRM.6.20	Support the following business processes for RiteShare (RS):	☐
PRM.6.20.1	Process RS co-payment claims	☐
PRM.6.20.2	Manage RS direct member payment accounts	☐
PRM.6.20.3	Process RS payments and process direct member cost-share deductions	☐
	Generate employer-sponsored insurance premiums to members or employers as directed by EOHHS	☐
PRM.6.20.4	Report RS detail to EOHHS including deposits, payment totals, exception payments, refunds, not sufficient fund checks, and premiums paid for RS members	☐
<i>PRM.7.0</i>	<i>Performance Improvement Team</i>	☐
PRM.7.1	Staff the EOHHS Process Improvement Team which researches potential cost savings solutions and completes other special projects as assigned	☐
PRM.7.2	Support Program Integrity through preparation and facilitation of multiple, annual CMS, other federal audits, and the SAS70 audit	☐
<i>PRM.8.0</i>	<i>Quality Assurance</i>	☐
PRM.8.1	Implement quality assurance measures (self-audits) to ensure consistency and correctness of entered operations management information, achievement of SLAs, and share the information with the State on a monthly basis	☐
<i>PRM.9.0</i>	<i>Reporting and Data Analysis</i>	☐
PRM.9.1	Operate the Data Warehouse component of the MMIS. Develop and generate reports defined and on a frequency established by EOHHS	☐
PRM.9.2	Provide timely information to support State and Federal program initiatives and reporting requirements	☐
PRM.9.3	Provide uniform cut-off points (dates) for every report to ensure the consistency of all reports	☐
PRM.9.4	Ensure that changes made to benefit packages and programs, to category of service, provider type and specialty carry through to and across reports	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
	and is documented	
	Ensure the accuracy of all reports before delivery to the State	☐
PRM.9.5	Reconcile and 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	☐
PRM.9.6	Notify the State of any imbalances existing in the MARS reports, including the reason for the imbalance upon discovery	☐
PRM.9.7	Support State staff with inquiries resulting from the balancing procedures. Modify or add balancing procedures, as required by the State	☐
PRM.9.8	Deliver reports on a variety of media, including online, hard copy, or other electronic media as specified by the state	☐
PRM.9.9	Modify the MARS reports to ensure compliance with changes in State and Federal reporting regulations, changes to standardized reporting elements and new formats	☐
PRM.9.10	Provide technical assistance as needed to assist users in researching problems, reviewing production outputs, and understanding report formats	☐
PRM.9.11	Maintain and distribute up-to-date MARS documentation to designated state users and/or locations	☐
PRM.9.12	Provide information to support institutional rate setting, capitation fee setting, and/or cost settlements by program	☐
PRM.9.13	Create new data and data linkages based upon State directives	☐
PRM.9.14	Maintain the DW data dictionary and data relationships of fields and elements. Elements and fields must be defined so that they are understandable for the end user	☐
PRM.9.15	The DW must maintain data files, as necessary, to meet all Federal and State requirements and to produce Federal reports and State reports	☐
PRM.9.16	Maintain data warehouse documentation and make it available to the State in a format useful by the State	☐
PRM.9.17	Support modifications to DW reports currently in production	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
PRM.9.18	Support the development of new DW standard and ad-hoc reports as requested by the state	☐
PRM.9.19	Produce CMS 2082 in Federal and State hard-copy format for verification and DHHS use and in Federal Medicaid Statistical Information System (MSIS) electronic format for submission to CMS	☐
	Member Management Business Area	
<i>MEM.10.0</i>	<i>Dental Benefits Manager (DBM)</i>	
MEM.10.1	Data enter the DBM member enrollments and disenrollments provided by EOHHS into the MMIS	☐
<i>MEM.11.0</i>	<i>Managed Care Services</i>	
MEM.11.1	Provide services regarding managed care premium billing and payment, enrollment and disenrollment actions and reinstatement decisions for Rhode Island's managed care programs (see PRM.6.18 through 6.20.4)	☐
MEM.11.2	Maintain current and historical managed care eligibility information in the MMIS based on data from InRhodes and Rite Care/Share systems.	☐
MEM.11.3	Manage disenrollments and reinstatements in managed care programs according to Rhode Island policy. Provide appropriate data to InRhodes regarding disenrollments for non-payment of premiums.	☐
MEM.11.4	Provide assistance to State staff in responding to employer and client questions regarding enrollment, disenrollments and premium issuance and collection.	☐
<i>MEM.12.0</i>	<i>Other Member Services</i>	☐
MEM.12.1	Maintain the Language Web Directory ("Ask Rhody") on the Web in English, Spanish and Portuguese. (Note: The current FA works with the United Way to support maintenance of this directory)	☐
MEM 12.2	Administer the Incentive Card program, including but not limited to the following functions:	☐
MEM 12.2.1	• Issue and mail incentive cards to recipients on a weekly basis	☐
MEM 12.2.2	• Coordinate the funding of the account and provide oversight of the data transmission for the production of the incentive cards	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
MEM 12.2.3	Forward the data file for incentive payments within three (3) business days of receipt from EOHHS	☐
	Provider Management Business Area	
<i>PRV.13.0</i>	<i>Provider Enrollment</i>	
PRV.13.1	Operate and maintain the Provider Management System according to current and future Federal MMIS certification requirements, Part 11 of State Medicaid Manual and according to all State requirements	☐
PRV.13.2	Operate the provider enrollment and re-enrollment review and approval function of the MMIS	☐
PRV.13.3	Provide staff knowledgeable in all Federal and State provider enrollment and re-enrollment regulations	☐
PRV.13.4	Receive and process provider enrollment and re-enrollment information, including reviewing for completeness, obtaining missing information, performing eligibility approval, and enter approved data into the provider file	☐
PRV.13.5	Develop and print, subject to State approval, provider enrollment forms	☐
PRV.13.6	Distribute hard-copy provider enrollment forms based upon requests from providers	☐
PRV.13.7	Notify providers of acceptance/rejection as a Medicaid provider and send accepted providers required information for the provision and billing of Medicaid services	☐
PRV.13.8	Send termination notices to providers	☐
PRV.13.9	Generate and distribute State and Federal billing guidelines and Medicaid compliance guidelines	☐
PRV.13.10	Forward provider enrollment appeals along with relevant documentation to the State for review	☐
PRV.13.11	Assist the State in developing and maintaining detailed guidelines and procedures to ensure proper enrollment and re-enrollment of all provider types	☐
PRV.13.12	Handle all provider enrollment activities for out of state providers	☐
PRV.13.13	Maintain and store hard copy and/or electronic copies of provider materials for all approved and denied providers. The file for approved providers	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
	must contain the application, provider agreements, copy of provider license, and all correspondence relating to enrollment or re-enrollment resulting in a provider file update. Files for denied providers will include applications and/or profile information and documentation regarding the reason for the denial	
PRV.13.14	Process provider sanctions according to State guidelines	☐
PRV.13.15	Produce an annual report to ensure compliance with the False Claims Act	☐
PRV.13.16	Operate and maintain the trading partner enrollment management function of the MMIS	☐
PRV.13.17	Process provider requests for information and/or TPA forms	☐
PRV.13.18	Process submitted TPAs	☐
PRV.13.19	Maintain procedures for TPA distribution and collection	☐
PRV.13.20	Ensure completed TPA is returned by the provider prior to testing electronic data exchange	☐
PRV.13.21	Annually verify TPA data	☐
PRV.13.22	Ensure the master provider file has been updated prior to the claims processing cycle	☐
PRV.14.0	Provider Services Call Center	
PRV.14.1	Maintain and staff a Provider Services Call Center to include toll-free telephone lines that are accessible according to a EOHHS-approved schedule	☐
PRV.14.2	Monitor and report call center metrics, such as call abandon rate, call length, hold time, ring busy time, peak hour statistics, and speed of answer, to demonstrate compliance with all applicable SLAs (Appendix J)	☐
PRV.14.3	Respond to an unlimited number of calls per Provider	☐
PRV.14.4	Provide EOHHS approved educational scripts for callers on hold or waiting in queue	☐
PRV.14.5	Review scripts regularly to determine if revisions are necessary and report recommendations to EOHHS	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
PRV.14.6	Document call information as specified by EOHHS	☐
PRV.14.7	Monitor, record, and audit calls for quality control, customer service, program integrity, and training purposes. Vendor shall document and retain results on all calls and submit documentation to EOHHS upon request	☐
<i>PRV.15.0</i>	<i>Provider Training and Outreach</i>	
PRV.15.1	Develop and submit for State approval the annual provider training and meeting plan. This plan shall include training for State designated organizations and, when appropriate, personnel from EOHHS and other departments. The Provider training and meeting plan shall include standard training and other additional needs identified by the State	☐
PRV.15.2	Deliver regularly scheduled education for newly certified Medicaid providers and new provider staff about the basic information on the Rhode Island Medicaid program, including, but not limited to the following:	☐
PRV.15.2.1	• Claims processing system	☐
PRV.15.2.2	• Proper billing and prior authorization procedures	☐
PRV.15.2.3	• Enrollment process	☐
PRV.15.2.4	• Communication processes (both manual and electronic)	☐
PRV.15.3	Deliver education training through regular regional workshops, training sessions, and presentations at professional association meetings	☐
PRV.15.4	Develop and distribute surveys to providers soliciting their feedback regarding available training, services provided, service levels, programs, processes, procedures, and ideas for improvement	☐
PRV.15.5	Provide training ad-hoc sessions based on requests from the State	☐
PRV.15.6	Deliver special in-depth training to providers, who have been identified (by the vendor, by the State, or by the provider's association) with certain problem characteristics, including, but not limited to, the following:	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
PRV.15.6.1	Abnormal number of claims denied or suspended	☐
PRV.15.6.2	Abnormal number of problems with the prior authorization process (e.g., high number of errors, modifications, returns, or denials)	☐
PRV.15.6.3	Repeated problems with enrollment or re-enrollment	☐
PRV.15.6.4	Abnormal number of problems using the contractor's system	☐
	Care Management Business Area	
<i>CRM.16.0</i>	<i>Radiology Management</i>	
CRM.16.1	Perform Radiology Management services including Prior Authorization (PA) for radiology services	☐
CRM.16.2	Review requests along with history in the MMIS to ensure medical necessity and a prior auth or denial that is consistent with clinical guidelines and state policy on radiology procedures	☐
CRM.16.3	Send approvals electronically to the MMIS to support claims processing	☐
CRM.16.4	Generate reports on the PA processing and results and provide to EOHHS on a monthly and quarterly basis	☐
CRM.16.5	Provider helpdesk must support calls from providers on radiology management	☐
<i>CRM 17.0</i>	<i>Professional Clinical Services</i>	
CRM.17.1	Provide two (2) Dental Consultants credentialed with a dental specialty of orthodontics. These dental consultants are responsible for reviewing prior authorization requests for orthodontic services	☐
CRM.17.2	Provide two (2) Clinical Consultants trained as psychologists, one (1) trained as a physical therapist and one (1) trained as an occupational therapist. The staff is located at the EOHHS facility and uses EOHHS assets including workstations, phones, and other office equipment as EOHHS supplies its own employees at no cost to the Fiscal Agent	☐
	Surveillance Utilization and Review (SURS) Business Area	
SUR.18.1	Operate and maintain the SURS Management system according to current and future Federal MMIS certification requirements, Part 11 of the	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
	State Medicaid Manual, and according to all State requirements	
SUR.18.2	Operate the Data Matches function within the MMIS Program Integrity business area	☐
SUR.18.3	Perform activities to proficiently and proactively detect:	☐
SUR.18.3.2	Potential fraud, abuse or misuse by all providers and members	☐
SUR.18.3.3	Inappropriate billings and over payments, and violations by providers	☐
SUR.18.3.4	Significant percentage increase or decrease in provider's claims	☐
SUR.18.4	Notify State if potential fraud is suspected or reported by the recipient	☐
SUR.18.5	Receive and take action on correspondence received from the State	☐
SUR.18.6	Create and perform other provider audit profiles as directed by the State	☐
SUR.18.7	Provide staff to support provider audit applications and conduct field audits as necessary	☐
SUR.18.8	Schedule for the SUR run to coincide with the Federal Fiscal Year	☐
SUR.18.9	The FA vendor will produce the scheduled SUR reports and inform EOHHS of their availability	☐
SUR.18.10	Initiate and follow up on provider or member reviews as directed by the State when information is received through the following:	☐
SUR.18.10.1	SUR reporting exceptions, or profiles	☐
SUR.18.10.2	Complaints	☐
SUR.18.10.3	Referrals from State and federal agencies	☐
SUR.18.10.4	Referrals from health care providers	☐
SUR.18.10.5	Global cases – national cases involving numerous parties, such as states, the Department of Justice or Medicaid Fraud Control Units	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
SUR.18.10.6	• Explanation of Benefits (EOB)	☐
SUR.18.11	Record cases selected for review in the provider or member case tracking management tool	☐
SUR.18.12	Record complaints and non-formal referrals in the provider case tracking management tool	☐

State Responsibilities

The State will support Operations activities as follows:

- Review the FA's Monthly Report Card showing actual versus required performance on all SLAs;
- Review and approve or require revisions to CAPs for correction of any missed KPIs;
- Request supporting reports and data on the Monthly Report Card as needed;
- Monitor FA Staff Operations and System Operations on an ongoing basis; and
- Facilitate coordination of activities involving multiple State staff, agencies or programs.

5.4.2. Maintenance

The FA shall be responsible for maintaining the MMIS throughout the term of the contract. The MMIS, and its related programs, systems and functions must be updated and maintained by the FA according to federal certification requirements, the State Medicaid Manual, all federal mandates, and all State requirements, statutes, and regulations. This section of the SOW describes activities, deliverables and responsibilities for maintenance of the Rhode Island MMIS.

The FA will perform software maintenance for the MMIS and its supporting programs after Transition activities are complete and approved. Maintenance activities will be included under the terms of the contract's firm fixed price for MMIS Systems Costs, as detailed on the Cost Schedules C.1 through C.5 and incorporated into the final Contract. Maintenance activities include machine time, staffing hours, testing, documentation support, and any other related support required to fully maintain the MMIS and supporting systems.

Maintenance activities include at a minimum:

- Activities necessary to provide for continuous effective and efficient operation of the system to keep it ready and fit to perform at the standard and condition for which it was approved;
- Activities necessary to ensure that all data and programs are current and errors are corrected;
- Activities necessary to meet CMS certification requirements that exist at the time of contract award;
- Addition of new values and changes to existing system tables, reference tables and conversion of prior records, as necessary;
- Activities related to file growth and partitioning;
- File maintenance activities for updates to all files;
- Scheduled ongoing tasks to ensure system tuning, performance, response time, database stability and processing;
- Changes to the job scripts or system parameters concerning the frequency, number and media of reports;
- Updates to software, operating systems or other system components requiring version updates, manufacturer “patches,” and other routine manufacturers’ updates to software;
- Maintenance of security for user accounts; and
- Responses to production problems and emergency situations according to State-approved guidelines.

Operational Problem Management

The FA is to provide operational problem management to manage MMIS problems as they occur during Maintenance and Operations. The FA is to provide software tools to enable the tracking of a specific defect from identification through correction, including all testing performed to ensure the correct fix is in place. The FA is to categorize and resolve errors as follows:

- **Priority 0 Errors.** Critical business impact. Indicates MMIS is unavailable for use resulting in a critical impact on operations. Requires immediate State notification within one (1) hour of problem discovery and resolution within two (2) hours.
- **Priority 1 Errors.** Serious business impact. Indicates serious production issues where the MMIS is usable but is severely limited and no workaround exists. Requires immediate State notification within one (1) hour of problem discovery and resolution within twenty-four (24) hours.
- **Priority 2 Errors.** Significant business impact. Indicates moderate production issue where MMIS is usable but a workaround is available (not

critical to operations). Requires State notification within one (1) hour of problem discovery and resolution within five (5) business days.

- **Priority 3 Errors.** Minimal business impact. Indicates the problem results in little impact on operations or a reasonable circumvention to the problem has been implemented. Requires State notification within one (1) hour of problem discovery and resolution within an agreed-upon schedule between the Contractor and the State (as defined by the State).

Monitoring and Reporting

The status of all maintenance activities will be reviewed at the weekly and monthly meetings. These processes are described in Section 5.4.3 of this RFP.

Fulltime support for MMIS system maintenance must be provided onsite in Rhode Island by the Systems Manager and maintenance team members. The Systems Manager shall serve as the primary liaison between the maintenance staff resources and State staff for all system changes.

Deliverables

The FA will prepare the following deliverables in support of Maintenance Activities:

- Operational Problem Reports and associated CAPs;
- Impact Assessments for maintenance activities that result in a change to the system;
- Maintenance Test Plans as required by the State;
- Maintenance Test Results as required by the State;
- State-approved updates to Systems Documentation, User Manuals, Operating Procedures and Provider Manuals as required;
- Online tracking system and summary documents for all Work Requests from submittal of the request through implementation and documentation; and
- CAPs, as needed, to address operational deficiencies.

Fiscal Agent Responsibilities

The FA will support Maintenance activities as follows:

- Provide qualified systems staff to perform maintenance in a timely manner according to SLAs in Appendix J to this RFP and priorities established by the State;
- Develop and submit all required deliverables for State approval;
- Inform the State when a system deficiency is identified according to the priorities established in this section and defined in the SLAs in Appendix J to this RFP;

- Submit Operational Trouble Reports as required by EOHHS;
- Submit Work Requests, including CAPs, when operational problems occur within the timeframes specified in the SLAs and KPIs in Appendix J to this RFP;
- Perform all activities relative to the correction of deficiencies within the timeframes stated in this section and the SLAs and KPIs in Appendix J to this RFP;
- Correct all errors and discrepancies found in the operational system at no additional charge for computer or human resources needed to maintain or correct the system;
- Provide consultation to the State in the identification of deficiencies and maintenance and the development of Work Requests to modify the system;
- Submit system changes for proposed system maintenance identified by the FA;
- Develop and submit an Impact Assessment for maintenance activities that result in changes to the system;
- Maintain an online system for tracking and reporting of maintenance and modification projects;
- Participate in weekly and monthly status meetings with the appropriate State staff to report progress and discuss maintenance status and specifications;
- Prepare and submit a Maintenance Test Plan for approval, when required by the State for major maintenance efforts;
- Perform systems tests of all maintenance changes proposed prior to implementation of those changes;
- At the State's option, assist in the performance of acceptance testing;
- Submit Maintenance Test Results to the State for approval when required by the State for major maintenance efforts;
- Implement changes (maintenance) upon State approval;
- Verify the successful implementation of the fix or other maintenance effort, including monitoring accuracy of processing, and correction of any problems;
- Update Systems Documentation, User Manuals, Operating Procedures and Provider Manuals, as required by the State, within thirty (30) business days of implementation of a fix or other maintenance or as specified by the State. Changes to reports resulting from systems changes must accompany the first production of the report;

- Identify changes to business processes required as a result of fixes or other maintenance;
- Train State and provider staff on changes resulting from systems changes resulting from maintenance efforts; and
- Take over implementation of maintenance in progress at the time of contract start as designated in the contract (if applicable).

State Responsibilities

The State will support the Maintenance activities as follows:

- Participate in weekly and monthly status meetings with the FA to monitor progress on maintenance and modification activities;
- Review and determine approval for the FA Work Requests addressing system deficiency, when identified;
- Review Operational Problem Reports submitted by the FA, and monitor corrective actions;
- Review Maintenance activities deliverables and approve, deny or require changes;
- Review Impact Assessments and approve, deny or request additional information;
- Determine the priority for FA completion of system maintenance and modification activities;
- Designate each Work Request as a maintenance or modification activity
- Monitor FA Maintenance activities;
- Require development of Maintenance Test Plans as appropriate for major maintenance efforts;
- Perform user acceptance testing, if desired;
- Review and approve updates to Systems Documentation, User Manuals, Operating Procedures, and Provider Manuals;
- Approve implementation of fixes or other maintenance into the production environment; and
- Provide signoff that maintenance is approved.

5.4.3. Modifications

The Rhode Island MMIS is subject to ongoing modification due to federal and State regulatory and policy changes, Medical Assistance program initiatives, and technological innovations in the industry. The FA must provide the appropriate engineering and analysis expertise to remain responsive to changing system

requirements. This section of the SOW describes activities, deliverables and responsibilities for modifications to the Rhode Island MMIS.

Historically, Rhode Island has approved approximately 20,000 hours per year for modification of its MMIS. Two thousand (2,000) hours for modifications are included in the MMIS Systems Costs over the five (5) base years of the contract. Additional hours for modification will be paid at the hourly rate bid on Pricing Schedules C.

The State has identified one modification activity that will be in progress at the time of transition. The new MMIS FA will take over implementation of the ICD-10 code set and associated 837 modifications on a schedule determined by the State and designated in the final contract. The Business Design Document for this modification, including the anticipated schedule and status at the time of takeover, is included in the Bidders' Library.

The State does not anticipate the transition of other modification activities currently in progress. As new modifications are identified after issuance of this RFP, the State will decide whether each will be performed by the current or new MMIS FA. Payment for newly identified modifications will be made according to Section 9.2.19 of this RFP.

The FA must perform software modifications for all components of the MMIS following completion of Transition activities and approved Start of Operations, as requested by State. Some major program initiatives may require a prior approved Advance Planning Document (APD). The FA is responsible for providing information needed for inclusion in the APDs, which will be submitted by the State.

Process

The State or FA may submit Work Requests for changes to the MMIS and related systems. Work Requests will be classified as either a maintenance or modification effort, as described in this section and Section 5.3.2 of this RFP.

Examples of modification activities include:

- Implementation of capabilities not specified in this RFP or agreed to during design and development;
- Implementation of edits and audits not defined in the current MMIS;
- Activities necessary to meet new or revised CMS or other federal or Rhode Island requirements; and
- Changes to established report, screen, or database formats, such as sort sequence, new data elements, or report items.

Work Requests will be reviewed on at least a weekly basis at designated meetings with FA and State staff. The FA will document and log Work Requests for review at the weekly meetings. The FA will maintain an online tracking system of all Work Requests that provides a detailed description of the effort as well as the status from submittal through implementation and documentation.

The FA will maintain a summary log, updated weekly, of all Work Requests, including information specified by the State. The report will be available online for access by both State and FA staff. Online tracking and the summary report will be accessible by State staff.

The FA will provide an Impact Assessment of each Work Request within five (5) business days after submittal. The Impact Assessment will include:

- A description of the scope of work involved;
- A breakdown of the work effort by deliverable;
- A breakdown of the work effort by hours within each job classification;
- An implementation schedule, and, if appropriate, revised schedules for all other concurrently approved projects or Change Requests impacted; and
- The FA's proposed categorization of the effort as either a maintenance or modification activity. A statement of the scope of the change request in relation to business functions, functions, features, and capabilities to be changed.

Upon receipt of the Impact Assessment, the State will approve, require revisions or request additional information from the FA. The State will designate each effort as a maintenance or modification effort. Work Requests designated as system modifications will be managed through a Change Management process described in Section 5.2 of this RFP.

The FA will be required to produce a Business Design Document for major system modifications, as designated by the State. Requirements for Business Design Documents are included in Section 5.5 of this RFP. State approval of the Business Design Document will be required prior to start of work on system modifications requiring a Change Order.

The FA will be required to submit a Modification Test Plan for each modification for State approval. Upon completion of testing, the FA will submit Modification Test Results to the State for approval. Modification Test Plans and Modification Test Results must meet the requirements for System Test Plans and System Test Results specified in Section 5.5 of this RFP.

Implementation (move to production) will occur only after State approval of the Modification Test Results. The FA will make any appropriate changes to Systems Documentation, User Documentation, Operating Procedures and Provider Manuals within twenty (20) business days of implementation or as required by the State.

Monitoring and Reporting

The status of all Work Requests, maintenance, and modification activities will be reviewed at the weekly and monthly meetings. The weekly meeting will focus on FA reporting of progress against schedules, any proposed schedule revisions, discussion of specific details on Work Requests, maintenance and modifications and review of deliverables. Monthly meetings will summarize and highlight monthly progress and may be combined with other monthly status meetings.

The FA will produce a weekly Modification Hours Expended report showing modification hours expended by week by Work Request by staff member, showing subtotals and totals.

At a minimum, fulltime support for Modification Activities must be provided onsite in Rhode Island by the Systems Manager and maintenance team members. The systems manager shall serve as the primary liaison between the modification team resources and State staff for all system changes.

Deliverables

The FA will prepare the following deliverables in support of Modification activities:

- Work Requests submitted by either State or FA staff;
- Impact Assessments of each Work Request;
- Change Orders for major system modifications, as designated by the State;
- Business Design Documents as required by the State;
- Modification Test Plans;
- Modification Test Results;
- State approvals of Modification Test Plans and Modification Test Results;
- State-approved updates to Systems Documentation, User Manuals, Operating Procedures, and Provider Manuals (as required);
- Online tracking system and summary documents for all Work Requests from submittal of the request through implementation and documentation; and
- Weekly Modification Hours Expended reports.

Fiscal Agent Responsibilities

The FA will support Modification activities as follows:

- Provide qualified systems staff to perform modifications in a timely manner according to priorities established by the State;
- Develop and submit all deliverables for State approval;
- Provide consultation to State in the development of modification requests for inclusion in APDs;
- Submit Work Requests for proposed system modifications identified by the FA;
- Develop and submit an Impact Assessment with each Work Request;
- Maintain an online system for tracking and reporting of maintenance and modification projects;

- Participate in weekly and monthly status meetings with the appropriate State staff to report progress and discuss modification specifications;
- Submit a Business Design Document to detail FA proposed changes in response to system modifications that have been approved and assigned for implementation;
- Prepare and submit a Modification Test Plan for approval, when required by State;
- Perform systems tests that include unit testing, functional testing, regression testing using automated regression testing tools, and user acceptance testing;
- At State's option, assist State in the performance of acceptance testing;
- Submit Modification Test Results to the State for approval;
- Implement modifications upon State approval;
- Verify the successful implementation of the modification, including monitoring accuracy of processing, and correction of any problems;
- Update Systems Documentation, User Manuals, Operating Procedures and Provider Manuals, as required by the State, within twenty (20) business days of implementation of a modification or as specified by the State. Document report changes to accompany the first production of the report;
- Identify changes to business processes required as a result of modifications;
- Train State and provider staff on changes resulting from systems modifications; and
- Take over implementation of modifications in progress at the time of contract start as designated in the contract.

State Responsibilities

The State will support Modification activities as follows:

- Participate in weekly and monthly status meetings with the FA to monitor progress on maintenance and modification activities;
- Review Modification activities deliverables and approve, deny or require changes;
- Prepare and submit Change Requests identified by State staff to the FA;
- Review notices of proposed Work Requests and Change Requests submitted by the FA;
- Review Impact Assessments and approve, deny or request additional information;

- Determine the priority for FA completion of system maintenance and modification activities;
- Designate each Work Request and Change Order as a maintenance or modification activity;
- Develop and monitor Change Orders according to the Change Management Process described in Section 5.2 of this RFP for approved system modifications;
- Monitor FA Modification activities;
- Assist in development of Modification Test Plans as appropriate;
- Perform user acceptance testing if desired;
- Review and approve updates to Systems Documentation, User Manuals, Operating Procedures, and Provider Manuals;
- Approve implementation of modifications into the production environment; and
- Provide signoff for modifications that are approved.

5.5. Enhancement Activities

The enhancements to business and technical functionality are detailed in Sections 6 and 7 of this RFP.

The FA is responsible for all Enhancement Design, Development, and Implementation activities for the MMIS Transition and Enhancement Project including:

- System Design;
- System Development and Test;
- Implementation; and
- Operation.

The FA shall set the schedule of key dates and dates for submittal of major deliverables for EOHHS review during the Enhancement activities in the Project Work Plan. All deliverables dates and key dates are contingent upon EOHHS approval.

Following, each activity in the Enhancement activities is described in terms of State and FA responsibilities and FA deliverables.

5.5.1. Deliverables

The FA will prepare the following deliverables in support of Enhancement activities:

- Project Work Plan and Schedule – Work plan to include but not be limited to, tasks, dependencies, milestones, resources, and timelines;

- System Requirements Specification – System requirements to include, but not be limited to, defined use cases, functional requirements; and business requirements;
- Design Documentation – Detailed design of the enhancement to include but not be limited to architectural diagrams and descriptions, software design, security design and infrastructure design;
- RTM – Traceability to include, but not be limited to, tracing all system requirements to design elements;
- System Test Plans – Test plans to include but not be limited to testing unit testing, system integrated testing, and UAT;
- System Test Results – Results of system testing and associated reports;
- Operating procedures – Documentation to include, but not be limited to, operational procedures and maintenance activities to support the enhancement functionality
- User manuals – New or updated user manuals to include, but not be limited to, updates to the MMIS manuals and creation of new manuals for new functionality;
- Provider manuals – New or updated Provider manuals to support the new functionality;
- Disaster recovery plan – Updates to the MMIS disaster recovery plan, disaster readiness test plans to support the new functionality, and system changes;
- As-Built Design Documents – Documentation that captures the detailed deployment of the new functionality that includes, but is not limited to, capture of all system configurations, screenshots of installation steps, and all information necessary to recreate the deployment of the new functionality;
- State training plan - New or updated State training plans to support the new functionality, as applicable;
- Provider training plan - New or updated Provider manuals to support the new functionality, as applicable; and
- System Certification – After the enhancements are implemented, system certification will be required as described in Section 5.5 of this RFP.

Each FA deliverable must be delivered in electronic media and format compatible with EOHHS standards. The FA may choose to combine deliverables logically into fewer documents to avoid duplication and heavy cross referencing. EOHHS will review and provide formal approval for all deliverables. The FA must include the agreed upon time, per deliverable, in the project work plan for EOHHS staff to complete a review of each deliverable and to document their findings. Based on the review findings, EOHHS may:

- Grant approval;
- Reject portions of or the complete document;
- Request FA revisions be made; and
- State the inability to respond to the deliverable until a future-specified date.

The following describes the minimum requirements for each deliverable.

Work Plan Schedule for Enhancement Activities

An updated detailed Project Work Plan and Schedule is required from the FA early in the Enhancement activities. The purpose of the work plan is to reaffirm FA delivery dates presented in the FA 's proposal, to detail work activities, and to facilitate EOHHS's monitoring of FA progress based on deliverables and key dates as specified in the Project Work Plan. The Project Work Plan must be updated on a bi-weekly basis. At a minimum, the detailed work plan must include:

- Key dates, and dates for submittal of deliverables;
- Structure, using a breakdown of task, sub-task, and activity work steps within each of the major Enhancement activities:
 - o System design;
 - o System development and testing;
 - o UAT and implementation; and
 - o Operations;
- Description at the sub-task level which includes:
 - o Description of the sub-task;
 - o Proposed location for tasks to be performed;
 - o Definition of a work product;
 - o Personnel resources applied by name and level of effort, in hours;
 - o EOHHS resource requirements (staff and other);
 - o Duration of task;
 - o Dependencies;
 - o Assumptions;
 - o All required and proposed deliverables;
 - o Contingency and recovery procedures at the activity level;
 - o Gantt chart;
 - o PERT (Program Evaluation and Review Technique) or dependency chart; and

- o Resource (personnel and other) matrix by sub-task, summarized by total hours by person, per month.

Enhancement System Requirements Specification Document

The System Requirements Specification (SyRS) document is developed by the FA to contain detailed system requirements based on the functional requirements in Sections 6 and 7 of this RFP. The SyRS shall meet standards contained in IEEE Standard 1233-1998, Guide for Developing System Requirements. The FA will conduct JAD sessions with EOHHS stakeholders to support the creation of the SyRS. At a minimum, the SyRS must include:

- A detailed description of the hardware and software configuration;
- The SyRS must be organized to address each of the major areas for enhancement included in Sections 6 and 7 of this RFP;
- Apply a logical, specific and hierarchical numbering convention to all detailed requirements in the SyRS to facilitate tracking in the RTM;
- An overview of the system architecture and how components are integrated to meet RFP requirements;
- An identification of all internal and external interfaces; and
- An identification of linkages across business functions.

Enhancement Design Documentation

The DD shall identify how and where the SyRS documented requirements are met in the design. The DD(s) developed by the FA must address each of the major areas for enhancement as defined in Sections 6 and 7 of this RFP. At a minimum, the DD(s) must be available in hardcopy and in an electronic media and format compatible with EOHHS standards, and must include:

- A systems standards manual, listing all standards, practices, and conventions, such as, language, special software, identification of all test and production libraries, and qualitative aspects of data modeling and design;
- An identification of system files and processing architecture;
- A general narrative of the entire system and the flow of data through the system;
- A general narrative of each business function, describing business functions, features, and processes;
- A flow diagram of each business function, identifying all major inputs, processes, and outputs of the business function;
- Lists of all inputs and outputs, by business function;
- A listing and brief description of each file;
- Preliminary screen and report layouts;

- High and medium level batch flowcharts to the job, procedure, and program level;
- A logical data model, including entity relations;
- A high-level physical data model and a detailed physical data model, including entity relations;
- Preliminary screen and report narrative descriptions;
- Final network configuration with graphic layout of all network lines, switches, and all hardware/software detail;
- A preliminary training plan and description of training materials;
- A preliminary layout for user manuals; and
- A preliminary layout for the data element dictionary.

Enhancement Requirements Traceability Matrix

The FA shall implement an RTM for all SyRS requirements. The implementation of the RTM shall be accomplished with a tool contained in the FA's proposed solution. The RTM must have the following characteristics:

- Associate all project artifacts (design and test documentation) associated with each requirement;
- Track impacts to project artifacts when a requirement change takes place; and
- Produce reports for specific trace elements, including, but not limited to:
 - o Requirement to DD;
 - o Requirement to Test Case;
 - o Requirement to Test Results;
 - o Unsatisfied or Unallocated Requirements;
 - o Requirements by major Enhancement Area; and
 - o Requirements associated with Change Orders .

System Test Plans

The objectives of the testing activity are to:

- Conduct system development and perform unit, business function, and system integration testing to ensure the functionality identified in the requirements function as defined; and
- Demonstrate through integrated testing that all enhancements function as defined and that implementation of the project will not adversely impact other business functions.

The testing activity is designed to demonstrate that the new system functionality as installed, meets EOHHS specifications and performs all processes correctly.

All related MMIS business functions and modules will be tested, including the Disaster Recovery Plan changes as a result of the new functionality. Components of the test will require that the FA demonstrate readiness to perform all FA MMIS functions and contractual requirements, including manual processes. EOHHS will identify the schedule for test cycles and delivery of output. Testing will be conducted in a controlled and stable environment. The FA will be responsible for preparing the test environment, including data, and conducting the tests.

Minimum requirements are:

- A System Test Plan and schedule for each system module and business function, as well as for the integrated system. Integrated system testing must include testing all MMIS features including those which involve more than one business function;
- A description of test situations and expected test results;
- An organizational plan showing FA personnel responsible for testing;
- A discussion of management of the testing effort, including strategies for dealing with delays in the testing effort, backup plan, backup personnel, and related issues;
- Procedures for tracking and correcting deficiencies discovered during testing;
- A plan for updating documentation based on test results;
- Procedures for notifying EOHHS of problems discovered in testing, testing progress, adherence to the test schedule, and so forth; and
- A plan for organizing test results for EOHHS review.

System Test Results

Minimum requirements include:

- All test results, including screen prints, test reports, and test inputs, must be cross-referenced to the expected test results in the system test plan;
- Corrective actions taken and retest documentation must be maintained for all problems identified in the initial tests and all retests;
- System performance benchmarks resultant from the capacity analysis must be documented;
- Integrated system test results must be maintained that show that the system can perform all integrated functions and can process all claim types from input through reporting; specific claim records must be tracked by control number through the system; and
- A summary must be maintained of the status of testing, including numbers of problems identified by type of problem, numbers of problems corrected,

any significant outstanding issues, the effect of any findings on the implementation schedule, and any other relevant findings.

Operating Procedures

Operating procedures define the relationships and responsibilities of FA and EOHHS personnel for operations of the enhanced MMIS and its associated program enhancements. The Operating Procedures for new functionality implemented with the enhancements must be developed by the FA. Minimum requirements are:

- Procedures must be written in a step-by-step format;
- Instructions for sequential functions must follow the flow of actual activity;
- Operating procedures must contain a table of contents and be indexed;
- Include all procedures for MMIS operations including mailroom, cycle balancing, production control, file updates, and so forth;
- Descriptions of error messages for all fields incurring edits must be presented;
- Definitions of codes used in various sections of a manual must be consistent;
- Mnemonics used in operating procedures must be identified and must be consistent with panels, screens, reports, and the data element dictionary;
- Abbreviations must be consistent throughout the documentation;
- Instructions for making online updates will clearly depict which data and files are being changed; and
- Operating procedures must contain any internal reports used for balancing, or other internal reports, that are not MMIS outputs. All fields in reports must be defined, including detailed explanations of calculations used to create all data.

User Manuals

The FA must prepare updates to the MMIS user manuals for each business function affected by the enhancements. User Manuals must be created for the enhancements addressing new functionality for the MMIS, such as the enterprise-wide Care Management interface, the integrated Case Tracking tool for SURS, and the enhanced Call Center capabilities.

During operations, updates to User Manuals must be prepared in final form on all changes, corrections, or enhancements to the system prior to EOHHS sign off of the system change. The FA will be responsible for the production and distribution of all user manual updates in a timely manner. The following are minimum requirements for MMIS user manuals:

- The manuals must be available online and must facilitate updating. EOHHS requires one paper copy using 8-1/2" x 11" paper in three-ring

binder form, pages numbered within each section, and a revision date on each page. Revisions must be clearly identified in bold print;

- User manuals must be written and organized so that users not trained in data processing can learn from reading the documentation how to access the online screens, read business function reports, and perform all other user functions;
- User Manuals must be written in a procedural, step-by-step format;
- Instructions for sequential functions must follow the flow of actual activity and balance instructions with the inter-relationship of data and outcomes;
- User Manuals must contain a table of contents and an index;
- Descriptions of error messages for all fields incurring edits must be presented and the necessary steps to correct such errors must be provided;
- Definitions of codes used in various sections of a User Manual must be consistent;
- Mnemonics used in user instructions must be identified and must be consistent with windows, screens, reports, and the data element dictionary;
- Abbreviations must be consistent throughout the documentation;
- Field names for the same fields on different records must be consistent throughout the documentation;
- Each User Manual must contain tables of all valid values for all data fields, such as provider types and claim types. This includes codes and an English description, presented on panels, screens, and reports;
- Each User Manual will contain illustrations of panels and screens used in that business function, with all data elements on the screens identified by number;
- Each User Manual will contain a section describing all reports generated within the business function, which includes the following:
 - o A narrative description of each report;
 - o The purpose of the report;
 - o Definition of all fields in reports, including detailed explanations of calculations used to create all data and explanations of all subtotals and totals; and
 - o Definition of all user-defined, report-specific code descriptions; and a copy of representative pages of each report;
- Instructions for requesting reports or other outputs must be presented with examples of input documents and/or screens;

- All functions and supporting material for file maintenance, such as coding values for fields, must be presented together and the files presented as independent sections of the manual;
- Instructions for file maintenance must include both descriptions of code values and data element numbers for reference to the data element dictionary;
- Instructions for making online updates will clearly depict which data and files are being changed; and
- User Manuals will be used as the basis for user training, unless otherwise specified by EOHHS.

Provider Manuals

Provider Manuals are used to enable the provider community to submit claim records in the proper format for adjudication. Each manual must be specific to individual provider type(s) or groups of related provider types. The Provider Manuals for the MMIS must be updated to include the new functionality implemented with the enhancements changes to meet the requirements here. If the new functionality requires additional Provider Manuals, those must be developed by the FA to meet the requirements. The minimum requirements are:

- Include an introduction, a policy section developed by EOHHS, billing instructions, billing examples, and rate methodologies;
- Provide general program information and highlight differences in programs and in processes among programs;
- Contain a table of contents and be indexed;
- Describe provider enrollment and recertification procedures, general participation requirements, and termination procedures;
- Describe general medical record content and record retention procedures and audit procedures and responsibilities;
- Identify third-party resource identification and recovery procedures;
- Identify methods of verifying member eligibility, describe identification cards, describe all relevant member information supplied to the provider, describe each eligibility verification access method available and how to utilize it, and describe why this information is relevant to providing services;
- Identify covered services and service limitations;
- Identify reimbursement procedures, including copayment requirements;
- Identify any special forms needed and describe how to complete them and submit them, such as prior authorization (PA), or consent forms;
- Provide detailed billing instructions and filing requirements, for all billing methods, including Electronic Management Claims (EMC);

- Describe the process to do adjustments and make refunds;
- Describe utilization review and control procedures;
- Describe how to do provider inquiries; and
- Complete all of the above requirements for any enhancement if the respective enhancement is exercised by EOHHS.

Disaster Recovery Plan

The FA must revise the MMIS Disaster Recovery Plan to reflect changes identified during the development and testing process. It must provide updated pages reflecting any new system components and procedures to effectively recovery from a disaster.

As-Built Detailed System Design

The FA must revise the Detailed System Design to reflect changes identified during the development and testing process. It must provide updated pages reflecting the design of the system as it was built to EOHHS for review and approval.

State Training Plan

The State Training Plan identifies all the activities leading up to, and including, the training of EOHHS user staff, at all levels, in the proper use of the new system functionality. Minimum requirements are:

- Description of training materials;
- Description of training facilities (e.g., use of panels);
- Training schedule;
- Plans for remedial training; and
- Methodology to ensure continued training during the operations activity for new staff or staff changing positions (e.g., use of videotapes).

Provider Training Plan

The Provider Training Plan identifies all the activities leading up to, and including, the training of all provider types in proper billing procedures, and understanding of remittance advice/Minimum requirements are:

- Description of training materials;
- Training schedule for all provider types across the State and selected out-of-State providers;
- Providing experienced training staff throughout the contract period;
- Locations for training; and
- Plans for remedial and ongoing training during operations.

5.5.2. Fiscal Agent Responsibilities

The FA will support Enhancement activities as follows:

- Prepare an outline and obtain approval from EOHHS for the contents and format for each deliverable before beginning work on the deliverable;
- Obtain written approval from EOHHS on the final deliverables for each task;
- Revise deliverables, if required, using EOHHS review findings to meet content and format requirements;
- Report progress against the work plan for each task with weekly written status reports and provide a biweekly updated Project Work Plan and Schedule for the Enhancement activities;
- Attend weekly status meetings with EOHHS's Project Manager;
- Provide transcripts (minutes) of the all status meetings within three business days of the meeting;
- Deliver written status reports and updated Project Work Plans and Schedules one business day (24 hours) before the status meeting;
- Provide written notice to EOHHS upon completion of deliverables that require EOHHS review and approval; and
- Identify scope of work issues. Seek EOHHS approval before commencing work outside the scope of this RFP.

Additional Responsibilities

- Conduct JAD sessions with EOHHS stakeholders to support the creation of the SyRS;
- Establish all necessary telecommunications links with all specified State offices;
- Establish the electronic data processing environment necessary to operate the MMIS;
- Install, develop, modify, enhance, and test the MMIS software;
- Maintain a change control process to document discrepancies and their resolution and to manage changes to programs and libraries;
- Perform unit, business function, integrated, performance, and parallel system tests (where applicable) using automated testing tools to ensure that software programs function correctly, without error, and function within the Service Level agreements;
- Prepare the system test results deliverable and provide a walk-through of the business function, integrated and parallel system test results for EOHHS staff;

- Develop operating procedures and provide a walk-through for EOHHS staff;
- Prepare user manuals for all business functions and provide a walkthrough for EOHHS staff;
- Prepare or update provider manuals (where applicable) for all provider types and deliver to EOHHS for approval;
- Provide procedures for updates to the user manuals and distribution of manual amendments to all manual holders;
- Prepare provider bulletins for EOHHS approval announcing upcoming changes in the MMIS; and
- Develop a disaster recovery plan and provide a walk-through for EOHHS staff.

5.5.3. State Responsibilities

The State will support Enhancement activities as follows:

- Review and approve the proposed format and content of all task deliverables;
- Review FA deliverables, determine the approval status of the deliverable, and provide written comments to the FA the date set forth and agreed upon in the current Project Work Plan and Schedule;
- Conduct weekly status meetings with the FA to review progress against the Project Work Plan;
- Review and approve communications regarding all status meetings Review weekly written status reports and bi-weekly work plan and task schedule updates;
- Monitor FA progress to task deliverables;
- Analyze, authorize, and add to the contract, any changes to the scope of work as described in this RFP;
- Provide all available relevant documentation on current MMIS operations;
- Clarify, at the FA's request, EOHHS and division policy, regulations, and procedures;
- Determine or develop policy, where necessary;
- Make staff available to participate in the definition of general and detailed system and operational requirements;
- Review and approve (or request modification of) enhancement documentation, including function descriptions and flowcharts;
- Review and approve (or request modification of) identified inputs and outputs;

- Review and approve (or request modification of) preliminary screen and report layouts and descriptions;
- Coordinate communications links with EOHHS and the FA; and
- Advise the new FA of any changes being made to the current MMIS between the contract start date and the first day of the operations task.

5.6. Certification Activities

Following the transition of the Rhode Island MMIS to the new MMIS FA and implementation of enhancements described in Sections 6 and 7 of this RFP, the FA will be required to demonstrate to CMS and the State that the Rhode Island MMIS meets CMS certification requirements for an MMIS.

The MMIS transition activities and enhancements to the system that are implemented as a result of this project must meet all federal standards required by CMS for certification, as described in Part 11 of the State Medicaid Manual, in 42 CFR 433, Subpart C and 45 CFR 95.611(d), as well as subsequent laws, regulations, directives, and State Medicaid Director letters. The certification process also validates that the MMIS and related systems are operating as described in the prior approval documents, including APDs, RFPs and associated contracts submitted to CMS for the purpose of receiving FFP.

CMS issued the Medicaid Enterprise Certification Toolkit providing updated guidelines for certification of MMIS on September 28, 2007. Rhode Island has organized its re-procurement and enhancement efforts using the approach and checklists included in the Toolkit. Checklists stating State-Specific Business Objectives for all enhancements are included in Appendix O.4 to this RFP. Certification Toolkit checklists are included in the Bidders' Library. The new FA is expected to incorporate these checklists into its methodology for takeover of the current MMIS and implementation of the required enhancements.

The FA will assist in preparing for and will participate in the certification of the MMIS, including the preparation of certification documents, generating required reports, and ensuring that all MMIS certification requirements are met. CMS has indicated that it may limit the certification review to include only enhancements to the current MMIS. The FA will assume all costs incurred to obtain federal certification.

The State will continue to discuss the scope with CMS and provide the Successful Bidder with any updates available during the Contract Initiation and Start-Up activities. Regardless of the outcome, the successful Bidder will be responsible for the entire scope of certification requirements specified by CMS. The MMIS must perform all functions and possess all capabilities required by CMS at the time of certification.

The State will withhold ten (10) percent of payment for each enhancement until federal certification is obtained or CMS informs the State that certification will not be required.

The FA must maintain certification throughout the term of this contract. Payment provisions and penalties associated with failure to obtain or maintain certification are included in Section 9.2.76 of this RFP.

The MMIS must include all federally required data required at the time of certification. The MMIS must meet all performance requirements and standards contained or referenced in this RFP. It must also be capable of producing samples, reports, and other documentation that may be required for CMS review.

5.6.1. Deliverables

The FA will prepare the following deliverables in support of Certification activities:

- Updated Project Work Plan and Schedule addressing the activities to prepare for and support certification, including:
 - o Planned dates and milestones associated with certification review tasks and activities;
 - o Development periods and submission dates for materials and activities pertaining to CMS' certification review;
 - o Review periods (including State and CMS reviews) for materials developed in preparation for CMS' certification review; and
 - o Scheduled walkthroughs of MMIS subsystems, business areas, and documentation (system or user documentation, or other documents as requested by State or CMS);
- Post-Implementation Evaluation Report, which includes at a minimum:
 - o The current status of the MMIS and related systems and processes;
 - o Lessons learned (i.e., successes, failures, outcomes) from the Transition and Enhancement activities;
 - o Issues, risks and concerns and proposed resolutions;
 - o Benefits and improvements over the previous MMIS; and
 - o MMIS user satisfaction measured by a survey or other State-approved tool;
- Pre-Certification Review Materials, including certification folders (electronic and/or paper formats as requested by CMS) and all reports and data necessary to support certification;
- Updated CMS Medicaid Enterprise Certification Toolkit Checklists;
- Online and Physical Certification Review Repository, which contains materials or information that will be used to support the CMS certification review. The repository must adhere to State access and security guidelines;

- CAP in response to the CMS certification review results, including an approach and schedule for addressing certification review findings reported by CMS; and
- Documentation of Corrective Actions taken as part of the CAP.

5.6.2. **Fiscal Agent Responsibilities**

The FA will support Certification activities as follows:

- Submit an updated Project Work Plan and Schedule at least thirty (30) business days prior to the start of the scheduled Certification activities;
- Perform a Post-Implementation Review of the MMIS, associated systems and tools, and documentation (system and user) in preparation for CMS' certification review approximately six (6) months after full implementation of the Rhode Island MMIS Enhancements and at least thirty (30) business days prior to the CMS onsite certification review visit;
- Provide all State-specified personnel to participate fulltime onsite in the Post-Implementation Review;
- Develop the Post-Implementation Review Results deliverable, submit to the State at least fifteen (15) business days prior to the CMS certification review to the State for approval; make revisions as required;
- Review the State's current Medicaid Enterprise Certification Toolkit Checklists and provide updates prior to the start of the CMS MMIS certification review process;
- Prepare all reports and data necessary for the preliminary letter submission to CMS as outlined in the State Medicaid Manual, Part 11241 and the CMS Medicaid Enterprise Certification Toolkit;
- Provide personnel to brief appropriate State staff on certification procedures, system operations, and other information necessary for State staff to make appropriate presentations at the time of the certification review;
- Provide a walk-through of the FA facility(ies) and processes, if required by the CMS certification team;
- Provide MMIS expertise to answer questions or provide insight during the certification process;
- Prepare certification review materials in preparation for multiple meetings with CMS and the State in support of the CMS' certification review process. Materials may include:
 - o Meeting or walkthrough agendas and meeting minutes;
 - o Certification review folders with system or user documentation pertaining to the review of each MMIS business area;

- o Materials in presentation format as requested by the State or CMS in preparation for the review; and
- o Materials that support walkthrough of various MMIS components and processes by CMS and the State;
- Establish an online and physical repository of certification materials;
- Participate in and support CMS certification review meetings, onsite reviews and walkthroughs, or teleconference calls as requested by the State in preparation of, throughout, and after the CMS MMIS certification review;
- Work with the State to establish a CAP within a timeframe that is acceptable to CMS and the State; and
- Perform corrective actions and address deficiencies identified by CMS, in a manner that is acceptable to CMS and the State. Document corrective actions taken, and submit documentation to the State for management purposes.

5.6.3. State Responsibilities

The State will support Certification activities as follows:

- Direct the MMIS certification process and act as the contact with CMS during the certification process;
- Meet with CMS to obtain an understanding of its approach to certification of the Rhode Island MMIS;
- Prepare the MMIS certification letters to CMS;
- Review, request revision and approve the Certification activities deliverables;
- Review and approve FA-produced MMIS certification documentation;
- Review and respond to issues and risks reported by the FA;
- Establish requirements for the online and physical repository of certification review materials;
- Notify the FA of CMS certification review findings, and work with the FA to develop an approved CAP; and
- Monitor corrective actions and review documentation provided by the FA,

5.7. Turnover Activities

Prior to the conclusion of the contract, the FA shall provide assistance in turning over the enhanced MMIS, its associated programs, and related services to the State or its agent. The cost of all Turnover activities shall be included in the base contract. The FA shall be responsible for turning over the MMIS system and related operations and functionality related to the MMIS that is included in the

base contract. This includes, but is not limited to, operation of the EOHHS Website, the Consumer Direction Module (CDM) Website, the AskRhody Website and search engine, the Rite Resources Website and any other Websites hosted by the FA under the contract resulting from this procurement.

The State requires that the FA prepares for and participates in the process of turning over the artifacts required to operate the enhanced MMIS and its related services at the conclusion of this contract. The goal of the turnover process is to identify, provide, and, in some cases document, all the processes, tools and software required so that the MMIS and its related services can be operated by the State or its appointed agent. The support activities and documentation defined in this subsection are to ensure that the complete system may be run by an entity other than the FA. The Turnover activities and activities completed by the FA take place well in advance of the end of the contract and provide the State with multiple documents and training to allow either State personnel, or an agent appointed by the State, to independently operate the enhanced MMIS and its related services. All deliverables produced for turnover must be approved and accepted by the State prior to final payment.

5.7.1. Deliverables

The FA will prepare the following deliverables in support of Turnover Activities:

Turnover Plan

Before the start of the last year of the base contract period, the FA shall provide a Turnover Plan to the State. The plan shall include:

- Proposed approach to turnover;
- Activities for turnover;
- Project Work Plan and Schedule for turnover;
- Production program and documentation update procedures during turnover; and
- Description of vendor coordination activities that will be implemented to ensure continued system operation and services as deemed appropriate by the State.

At least six (6) months prior to the end of the base contract and at least six (6) months prior to the end of any contract extension; the FA shall provide an updated Turnover Plan.

MMIS and Related Services System Requirements Statement

Prior to the start of the last year of the base contract period, the FA shall furnish to the State, at no extra charge, a statement of the resources that would be required by the State or another FA to fully take over the system, technical, and business functions of the MMIS and related services outlined in the contract(s). The System Requirements Statement shall contain the information listed below.

- The Statement must include an estimate of the number, type, and salary of personnel required to operate the equipment and perform the other functions of the MMIS and related services. The statement shall be separated by personnel activity category, including minimally the following:
 - o Data processing staff;
 - o Computer operators;
 - o Systems analysts;
 - o Systems programmers;
 - o Programmer analysts;
 - o Data entry operators;
 - o Administrative staff;
 - o Clerks;
 - o Managers; and
 - o Professional and clinical personnel (e.g., nurses, MDs, pharmacists, etc.);
- The Statement shall include all facilities and any other resources required to operate the MMIS and related services, including:
 - o Data processing equipment;
 - o System and special software;
 - o Other equipment;
 - o Telecommunications networks;
 - o Office space; and
 - o Other resources;
- The statement of resource requirements shall be based on the FA's experience in the operation of the MMIS and related services and shall include actual FA resources devoted to the operation of the system.

At least six (6) months prior to the end of the base contract and at least six (6) months prior to the end of any contract extension; the FA shall provide an updated System Requirements Statement.

5.7.2. Fiscal Agent Responsibilities

The FA will support Turnover Activities as follows:

Provide Turnover Services

As requested by the State, but approximately six (6) months prior to the end of the base contract period or any extension thereof, the FA must transfer all source program code listings to the State.

As requested, but approximately six (6) months prior to the end of the base contract period or any extension thereof, the FA must transfer to the State or its agent, as needed, all source program code listings and a copy of the enhanced MMIS and related services, including:

- All necessary data and reference files on electronic media;
- All production computer programs on electronic media;
- Job scripts on electronic media;
- Data entry software;
- All other documentation, including user, provider, and operation manuals needed to operate and maintain the system on PC-compatible CD, using State approved software;
- Procedures for updating computer programs, job scripts, and other documentation;
- All archived job script output to include, at a minimum, job control statements executed, condition codes, system messages, start and stop dates and times, CPU time used, clock time used, and final file dispositions for each job step on electronic media, in a format specified by the State;
- All operations logs, process summaries, and balancing documents completed during the contract, in a medium and format specified by EOHHS at transition;
- All job scheduling software and reports used by operations;
- Hardware configuration diagram showing the relationship between all data processing and communication equipment necessary to operate the MMIS and related services, including local area networks, support networks, control units, remote job entry devices, storage devices, printers, control units, and data entry devices;
- All system macros (such as shell scripting and skeletal job scripts) used for job scheduling, data entry or system modification functions;
- As requested, but approximately four (4) months prior to the end of the contract or any extension thereof, the FA must provide updates to replacements for all data and reference files, computer programs, job scripts, and all other documentation as will be required by the State or its agent to run acceptance tests;
- At the option of the State, the FA shall arrange for the removal of hardware and software for the MMIS and related services, or the transfer to EOHHS of leases of equipment and software;
- At a turnover date to be determined by the State, the FA shall provide to State or its agent all updated computer programs, data and reference files, job scripts, and all other documentation and records as will be required by

the State or its agent to operate the Rhode Island MMIS and related services; and

- Following turnover of operations, the FA must provide EOHHS with a turnover results report, which will document completion and results of each step of the Turnover Plan.

Provide Training Services

As requested, but approximately five (5) months prior to the end of the contract or any extension thereof, the FA must begin training the staff of the State or its designated agent in the operation of the MMIS. Such training must be completed at least three months prior to the end of the contract or any extension thereof. Such training shall include:

- Claims processing data entry;
- Computer operations, including cycle monitoring procedures;
- Controls and balancing procedures;
- Exception claims processing; and
- Other manual procedures.

Provide Post-Turnover Services

To provide post-turnover support, the FA shall provide, at no charge to the State, the services of an onsite systems analyst who has worked on the MMIS at least one year. This individual shall be required to be on site for the 90 days following contract termination. The individual proposed by the FA must be approved by the State. The State will provide working space and will assign work to be done on a fulltime basis to support post-turnover activity.

The FA shall also be responsible for, and must correct at no cost, any malfunctions which existed in the system prior to transition or which were caused by lack of support at turnover, as may be determined by the State.

5.7.3. State Responsibilities

The State will support Turnover activities as follows:

- Review and approve a Turnover Plan to facilitate transfer of the operational responsibilities to the State or its designated agent;
- Review and approve a statement of staffing and hardware resources that would be required to take over operation of the MMIS and related services;
- Request Turnover services be initiated by the FA;
- Make State staff or designated State contracted staff available to be trained in the operation of the MMIS and related services;
- Coordinate the transfer of software and files for the MMIS and related services;

- Coordinate the termination or assumption of leases of hardware and software for the MMIS and related services;
- Review and approve a turnover results reports that document completion of each step of the Turnover Plan; and
- Identify the need for, and obtain post-turnover support from the FA at no extra charge for 90 days following contract termination, if required.

6. Functional Requirements

EOHHS conducted a MITA SS-A in preparation for the transition and enhancement of the MMIS. Recommendations from the MITA SS-A were used to define the functional requirements.

EOHHS has defined the following major areas for enhancement of the current MMIS:

- Care Management
- Cost-Savings Initiatives
- Customer Service
- Claims Processing
- Eligibility (Beneficiary Management)
- Managed Care
- Financial and Program Reporting

The first three areas, Care Management, Cost Savings Initiatives, and Customer Service include requirements for new functionality not currently done by the MMIS. Requirements for these are presented in a table for the Bidder to use in their response. Refer to this RFP at Section 4: Proposal Submission Requirements, for instructions on how to fill out the response form.

The remaining areas, Claims Processing, Eligibility, Manage Care, and Financial and Program Reporting include requirements for enhancements to the current MMIS functionality. These requirements are also presented in a table for the Bidder to use in their response. Refer to this RFP at Section 4: Proposal Submission Requirements, for instructions on how to fill out the response form

In addition to the defined requirements, the Successful Bidder will be required to conduct JAD sessions with the State. The JAD sessions for requirements definition must be included on the vendor's updated work plan which will be incorporated into the contract as a deliverable. Bidders should use their expertise in MMIS, Data Warehouse, and FA Services to ensure that any additional requirements required for the transition and enhancement of the MMIS, Data Warehouse, and FA services beyond those stated by the EOHHS are included and considered in all aspects of their proposal.

The detailed functional requirements are presented in the following sections.

6.1. Care Management Requirements

This section includes a narrative description and detailed requirements to support new Care Management functionality.

6.1.1. Narrative Description

This section includes a narrative description of the high-level requirements to support an enterprise-wide care management system. Functionality includes home and community based services, and related interfaces with managed care plans and primary care case management functions.

High-level requirements for Care Management include the following enhancements identified in the APD:

Implement an Enterprise-Wide Care Management System

The Successful Bidder will implement a Care Management System that integrates the oversight of client cases across EOHHS, including DHS, BHDDH, DCYF and DOH. The Care Management System will manage care plans for clients served by all designated programs and provide authorized access to case management information in a single system.

The Care Management System will maintain care plans and track services authorized and expended. It will interface with the MMIS to allow update of care plan information with submitted and adjudicated claims information. It will create prior authorizations for claims payment according to business rules specified by the agencies.

The State does not specify programs needing implementation during the Enhancement activities. However, the Katie Beckett program has been identified as a potential future care management candidate and can be utilized by the vendor as an example in the response to the RFP.

The Care Management System will interface with provider case management agencies to receive initial care management plans and updates, and will support exchange of data for reporting purposes.

6.1.2. Detailed Requirements

This section includes detailed requirements for the enterprise-wide care management enhancements to the MMIS.

Care Management focuses on the health needs of the individual including the plan of treatment, targeted outcomes and the individual's health status. Care Management requires collection of necessary health care data to manage the health outcomes of Rhode Island's citizens regardless of their path of entry into State-assisted medical services. Rhode Island's objective is to coordinate the management of cases across multiple agencies, including DHS, DCYF, BHDDH and DOH.

EOHHS is requesting a Web-based COTS package or application transferred from another state that is already in production.

The FA will be required to perform these activities to support Care Management functionality:

- Develop and implement a Care Management System for use by multiple programs administered by multiple agencies that meets federal

certification requirements, as included in Part 11 of the State Medicaid Manual;

- Support prior authorization of medical services as specified by EOHHS;
- Provide support to determine efficient and effective care, including incentive payments;
- Provide for unique identification of Care Management cases; and
- Support national coding initiatives such as 5010, ICD10, NCCI, etc.

The requirements are organized as:

- Inputs
- Processing
- Outputs
- Interfaces
- FA Responsibilities

Bidder acknowledges and accepts responsibility for the following requirements as indicated by checking the box in the column “Bidder Acknowledgment.”

Functional requirements for enhancements are presented in table format below. Complete checklists are included in Appendix O.1 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 23: Requirements for Care Management

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
Inputs					
CM.1.	Claims history of member services (paid, denied and pending), including claims for specific procedures, National Drug Codes (NDCs) and diagnoses as defined by EOHHS	☐	N/A		
CM.2.	Provider, member and reference data related to member's claim history	☐			
CM.3.	Electronic prior authorizations from the MMIS or EOHHS Data Warehouse	☐			
CM.4.	Electronic Preadmission Screening and Resident Review (PASRR) results from Qualidigm	☐			
CM.5.	Data entry of clinical information by case workers	☐			
CM.6.	Claims pending for medical review	☐			
CM.7.	Referrals for determination of medical necessity	☐			
CM.8.	Provide the ability to electronically accept and track forms submitted by providers	☐			
CM.9.	Other inputs including internal and external e-mails, faxes, telephone calls, letters and online referrals or inquiries	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
Processing					
CM.10.	The Care Management System must be deployed on the Web Foundation. (See Technical Requirements, Section 7 of this RFP)	☐	N/A		
CM.11.	The Care Management System must be integrated with the other applications through the ESB. (See Technical Requirements, Section 7 of this RFP)	☐			
Care and Case Management Data Maintenance					
CM.12.	Provide and maintain online Case and Care Management information for EOHHS and other agency Care Management programs, including, but not limited to EOHHS programs, such as: • Home and Community Care Preventive and Medically Complex Cases (DHS)	☐			
CM.13.	• Community and Assisted Living Waivers	☐			
CM.14.	• Nursing Home Transition Services	☐			
CM.15.	• Personal Choice Waiver	☐			
CM.16.	• Habilitation Waiver	☐			
CM.17.	• Shared Living Waiver	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.18.	Children's Respite Waiver programs	☐			
CM.19.	PACE	☐			
CM.20.	ConnectCare Choice/Diversion	☐			
CM.21.	SSI-Enhanced Assisted Living	☐			
CM.22.	Social Services for the Blind	☐			
CM.23.	Early Intervention	☐			
CM.24.	Children in fee for service programs	☐			
CM.25.	Katie Beckett	☐			
CM.26.	High-Cost cases	☐			
CM.27.	Other programs included in the Global Waiver demonstration	☐			
CM.28.	BHDDH case management programs, such as: CMAP	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.29.	• Methadone	☐			
CM.30.	• Various Substance Abuse programs	☐			
CM.31.	• Various MR and DD programs	☐			
CM.32.	• DD Day and Supported Employment	☐			
CM.33.	• Community Mental Health	☐			
CM.34.	• Inpatient Non-Hospital (IMD) care programs	☐			
CM.35.	Though now operated and maintained by an ASP vendor, review and make recommendations for the future operation of EOHHS's DEA case management programs, such as: • Co-Pay Day Care	☐			
CM.36.	• Co-Pay Home Care programs	☐			
CM.37.	• Assisted Living	☐			
CM.38.	• Nursing Home Transition	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.39.	DCYF case management programs, such as: • Various Residential Diversion programs	☐			
CM.40.	• Reunification Support programs	☐			
CM.41.	DOH case management programs, such as • Aids Drug Assistance Program and CNOM	☐			
CM.42.	• Breast and Cervical Cancer Treatment (BCCTP) treatment and screening programs	☐			
CM.43.	Provide the capability to link all members of a household, as defined by EOHHS, and to easily identify all members of a household, whether currently eligible or not	☐			
CM.44.	Provide the capability to query by: • All programs' member IDs	☐			
CM.45.	• Provider ID (NPI)	☐			
CM.46.	• Member name	☐			
CM.47.	• Provider name	☐			
CM.48.	• Member SSN (may need to be restricted by role)	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.49.	Disease/condition	☐			
CM.50.	Date of birth	☐			
CM.51.	Provide the ability to maintain, for each Care Management Plan, the following: Eligibility periods	☐			
CM.52.	Notification dates and responses	☐			
CM.53.	Assessment or screening schedules, dates and results	☐			
CM.54.	Case managers and primary care providers	☐			
CM.55.	Assessment or screening providers	☐			
CM.56.	Procedure codes and modifiers	☐			
CM.57.	Places of service	☐			
CM.58.	Dates of service	☐			
CM.59.	Referred services and providers	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.60.	Treatment objectives and goals, including detailed care plans	☐			
CM.61.	Treatment status for conditions identified for follow-up	☐			
CM.62.	Dates of member and provider notices and responses	☐			
CM.63.	Other data specified by EOHHS during the design sessions	☐			
CM.64.	Maintain case information to be used for other MMIS and EOHHS Data Warehouse processes, including claims adjudication, managed care, third party liability and mailings	☐			
CM.65.	Provide the ability for online updates and inquiries to care management data with assessment and screening results and dates, and referral and treatment dates for all conditions with access by SSN or member IDs	☐			
CM.66.	Provide the ability to add custom fields, all of which are reportable. Customized fields should include ability to populate lists such as: Dropdown lists (tables) that can be loaded with available resources (as defined by the State), e.g., transportation contacts, etc.	☐			
CM.67.	Dropdown lists (tables) that provide special program information	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.68.	Provide the ability to track payments for each member in total, and to limit payments to any combination of benefit plans based on total services or an overall dollar ceiling, as determined by the State. (e.g., Katie Beckett)	☐			
CM.69.	Provide the ability to flag members by: • High-cost thresholds by dollar amount	☐			
CM.70.	• Chronic illness	☐			
CM.71.	• Member's benefits package (program indicator and eligibility category)	☐			
CM.72.	Provide the ability to flag members and providers for any ongoing reviews of the member or provider	☐			
CM.73.	Provide the ability to flag members who receive or are recommended to receive restricted services for specified period of time and indicate start and end dates	☐			
CM.74.	Provide the ability to automate staff assignments and track progress and timing of all staff assignments	☐			
CM.75.	Provide a workflow process that maintains scheduled activities and generates tickler items as defined by EOHHS in design sessions	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.76.	Provide the ability to identify members referred for case management, those under case management, and those released from case management. Identify the care coordinator for each member.	☐			
CM.77.	Provide access to the status of related limitations for which the member has had services, such as the number of office visits paid per month	☐			
CM.78.	Provide patient and case-level alerts to caution care managers to specific conditions (e.g., disease management programs, quality reviews, litigation, coordination of benefits, language barriers, etc.)	☐			
CM.79.	Maintain data at the member and household level that spans all care for each member and permits case managers to share member information such as: Clinical findings and history	☐			
CM.80.	Psychosocial history	☐			
CM.81.	Laboratory	☐			
CM.82.	Pharmacy	☐			
CM.83.	Other information within defined parameters	☐			
Correspondence					

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.84.	Automatically generate notices and letters according to EOHHS criteria	☐			
CM.85.	Provide the ability to include free-form text into template letters	☐			
CM.86.	Provide the ability to send service reminder notices to providers or members	☐			
CM.87.	Provide the ability to accept online updates of notification responses, assessment/screening information, and status	☐			
CM.88.	Provide the ability to track member correspondence	☐			
Medical Reviews					
CM.89.	Provide the customization ability to add letters and notices without custom programming via an administrative module	☐			
CM.90.	Provide for unique identification of medical review cases	☐			
CM.91.	Provide the ability to set automated clinical, medical and administrative review criteria, such as electronic prior authorization requests and approvals	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.92.	Provide the ability to access clinical criteria and guidelines. Allows the user to enter and modify business and clinical rules through a user interface that offers control over criteria/guidelines without requiring developer intervention, such as: • Age	☐			
CM.93.	• Gender	☐			
CM.94.	• Provider	☐			
CM.95.	• Treatment setting	☐			
CM.96.	• Diagnosis(es)	☐			
CM.97.	• Procedure/service	☐			
CM.98.	Support the medical assessment process through a customizable electronic application to collect and document medical functional and clinical assessments by case workers and clinical staff. The core medical assessment questionnaire should have the flexibility to be customized by agency to meet specific program needs without the need of custom programming. It must be configurable to meet the needs of both medical and behavioral health programs	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.99.	Provide the ability to maintain a standardized library of customized assessment fields that can be shared by assessments of other programs, to allow easier integration with other Data Warehouse assessment data.	☐			
CM.100.	Provide for the creation of custom reports by program from the detailed assessment data.	☐			
CM.101.	Provide for online templates for medical decisions and requests for additional information to members, providers and referring parties	☐			
CM.102.	Provide the capability to assign acuity criteria	☐			
CM.103.	Provide concurrent review capabilities	☐			
Authorization of Services					
CM.104.	Allow authorization of services based on approval of care plans, assessments or other services by authorized users	☐			
CM.105.	Allow online update of the scope of services authorized, extend or limit the effective dates of authorization, and provide updates to the MMIS for adjustment or replacement of current prior authorizations	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.106.	Provide authorized users with access to all member claims and encounter history relative to the services considered for prior authorization	☐			
CM.107.	Provide the ability for the Care Management System to bypass or automate prior authorization requests for State-defined diagnosis-to-procedure combinations	☐			
CM.108.	Provide the ability to identify that services have been “authorized” and the ability to forward the decision to related parties (e.g., the referring person, the member, and the provider)	☐			
CM.109.	Provide reporting to identify authorized services per the previous requirement	☐			
CM.110.	Provide a mechanism to authorize and track traditional and non-traditional medical supplies and services purchased by the member enrolled in the self-directed waivers	☐			
Outputs					
CM.111.	Provide care management data to the EOHHS Data Warehouse on a schedule designated by EOHHS	☐			
CM.112.	Generate letters, correspondence and other materials to support care management activities, via an administrative module without the need for custom programming	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.113.	Generate prior authorizations to support the claims processing of services approved in member care plans. Automatically transmit PAs to MMIS via interface in standard HIPAA format.	☐			
CM.114.	Generate adjustments to prior authorizations based on modification of care plans by authorized users and transmit PA adjustments to the MMIS	☐			
CM.115.	Make the following types of reports available. Additional standard reports will be defined by EOHHS during the design sessions. • Reports that support all federal and State reporting requirements	☐			
CM.116.	• Medical review reports	☐			
CM.117.	• Members under care management (open and closed cases)	☐			
CM.118.	• Cost-saving reports	☐			
CM.119.	• Staff assignment and status tracking reports	☐			
CM.120.	• Activity list reports	☐			
CM.121.	• Healthcare Effectiveness Data and Information (HEDIS) type reporting	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.122.	Provide reports that support outcome and compliance tracking such as: • Prevention of specified diseases or conditions	☐			
CM.123.	• Reporting by specified diagnoses or groups of diagnoses	☐			
CM.124.	• Treatment services based on age groups	☐			
CM.125.	• Patient satisfaction data	☐			
CM.126.	• Mortality data	☐			
CM.127.	Provide the capability to analyze care being depicted as an episode of care, a global view of a beneficiary's treatment over time across all settings	☐			
CM.128.	Provide the ability to report by level of benefits or population such as TANF, SSI, SCHIP enrollees, by uninsured and by age grouping, children, adolescents, adults, or elderly	☐			
CM.129.	Provide reporting on quality improvement initiatives including but not limited to: • Intensive benefits management	☐			
CM.130.	• Pain management	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.131.	Prior authorization for high cost programs	☐			
CM.132.	Nursing Home Transition Program	☐			
CM.133.	Nursing Home Length of Stay	☐			
CM.134.	Foster Care Length of Stay	☐			
CM.135.	Preventative Care Program	☐			
CM.136.	Health Outcomes	☐			
CM.137.	Provide the functionality for ad-hoc reporting, data analysis, graphical data presentation, resulting in standard and parameter-driven reports	☐			
Interfaces					
CM.138.	Provide an automated interface with the MMIS to ensure timely and complete transmittal of member information, care plans and prior authorizations in standard HIPAA format	☐			
CM.139.	Provide for an interface with the EOHHS Data Warehouse for information from other agencies, DOH information (such as data of death and immunization information) and encounter data	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.140.	Provide a Web-enabled capability for the case record function to allow for authorized read and update access by contracted staff	☐			
CM.141.	Provide a Web-enabled capability for the case record function to allow for authorized read and update access by authorized contracted staff	☐			
CM.142.	Provide the ability to forward information via secure e-mail or the MMIS provider Web portal	☐			
Fiscal Agent Responsibilities					
CM.143.	Implement, maintain and operate the Care Management solution as defined by EOHHS during the design sessions	☐	N/A		
CM.144.	Scan, image and index all paper documentation and correspondence received and generated to support case management	☐			
CM.145.	Customize medical assessment applications to support the needs of State agencies, including DHS, DOH, BHDDH, and DCYF	☐			
CM.146.	Provide technical and training support for the Care Management solution, as specified by EOHHS during the design sessions	☐			
CM.147.	Incorporate audit trails to allow information on source documents to be traced throughout the processing stages. Maintain audit trails for five (5) years.	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.148.	Maintain user-friendly systems navigation technology and a graphical user interface that allows users to move freely throughout the system using pull-down menus, the ability to open and view multiple screens concurrently, and point-and-click navigation without identifying data multiple times.	☐			
CM.149.	Provide security at a field, record and user level. Limit access to medically sensitive information contained in a case through levels of security	☐			
CM.150.	Provide additional security levels for read and update at the field, record and user level for providers and contractors as authorized by EOHHS	☐			
CM.151.	Provide for context-sensitive help on screens for easy, point-and-click access to valid values and codes definitions by screen field	☐			

6.2. Requirements Supporting Cost Savings Initiatives

This section includes a narrative description and detailed requirements for enhanced cost savings initiatives.

6.2.1. Narrative Description

This section includes a narrative description of the high-level requirements to support Rhode Island cost-savings programs. Functionality includes TPL and program integrity.

High-level requirements for Cost Savings Initiatives include the following enhancements identified in the APD:

Improve Functionality to Support Cost-Savings Initiatives

The MMIS will be modified to support additional interfaces to identify TPL, track casualty cases, manage estate recoveries, and track cases identified under program integrity processing.

This section includes detailed requirements for the national and cost savings initiatives enhancements to the MMIS. Requirements are organized into two subsections: TPL and Program Integrity. The requirements for each area are organized as:

- Inputs
- Processing
- Outputs
- Interfaces
- FA Responsibilities

6.2.2. Detailed Requirements – Third Party Liability

The FA will implement functionality to support enhancement of TPL identification and recovery efforts, application of cost recoveries, accounts receivable processing, and the development of a multi-use Case Tracking tool for immediate use in Casualty and Estate Recovery efforts and SURS Integrity case tracking.

Bidder acknowledges and accepts responsibility for the following requirements as indicated by checking the box in the column “Bidder Acknowledgment.”

Functional requirements for enhancements are presented in table format below. Complete checklists are included in Appendix O.1 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 24: Requirements for Cost Saving Initiatives

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
Inputs					
TPL.1.	Trauma indicators on claims, which generate SWICA and questionnaires, and open a Casualty Recovery case in the Case Tracking tool	☐			
TPL.2.	Scanned responses to SWICA and questionnaires received from clients. Update MMIS TPL and Casualty Recovery Case Tracking information based on data received and scanned.	☐			
TPL.3.	Online updates to the tool by authorized users	☐			
TPL.4.	Data matches from other government programs, private insurance carriers and other State-specified sources identified by EOHHS in the design sessions	☐			
TPL.5.	Health coverage data including retroactive changes and State information from the State eligibility system, InRhodes	☐			
Processing					
TPL.6.	The FA will implement functionality and interfaces to support enhanced identification of TPL, improved cost recovery and assignment of cost recoveries. It will implement and maintain an application to track Casualty and Estate Recovery cases.	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TPL.7.	The Case Tracking System must be deployed on the Web Foundation. (See Technical Requirements, Section 7 of this RFP)	☐	N/A		
TPL.8.	The Case Tracking System must be integrated with the other applications through the ESB. (See Technical Requirements, Section 7 of this RFP)	☐			
Third Party Liability and Cost Recovery					
TPL.9.	Implement functionality to apply cost recoveries at the individual claim-level, as a single adjustment or mass adjustment	☐			
TPL.10.	Automatically process Medicare Part A, B, C, and D crossover claims and adjustments	☐			
TPL.11.	Generate a claims adjustment file for mass adjustment of claims when a case is settled	☐			
TPL.12.	Provide an automated multi-use Case Tracking tool allowing online access by specified users with the following functionality: Support workflow processes that create cases, trigger alerts, and allow for pending of work tasks	☐			
TPL.13.	Assign work items, cases and claims to staff by role and to staff by team	☐			
TPL.14.	Store and retrieve relevant case data	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TPL.15.	Provide a case notes feature that allows for documentation of case status, tracking of phone calls and correspondence	☐			
TPL.16.	Provide the ability to import claims history reports from the EOHHS Data Warehouse, based on case parameters such as member IDs, provider IDs, date spans, groups of procedures and diagnoses, as specified by EOHHS during the design sessions	☐			
TPL.17.	Provide the ability to attach scanned or imaged correspondence received from clients, attorneys and others related to the case	☐			
TPL.18.	Apply levels of security and access to certain processes and functions	☐			
TPL.19.	Automatically suspend certain work items or claims based on defined business rules for review at a later date	☐			
TPL.20.	Allow manual suspense of work items or individual cases and claims for review at a later date	☐			
TPL.21.	Automatically generate notices to supervisory staff when a work item or process is overdue	☐			
Estate Recovery The FA will implement a Case Tracking tool with workflow functionality that supports Estate Recovery, including:					

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TPL.22.	Automatically initiate an Estate Recovery case based upon receipt of a Date of Death on a member record by the MMIS	☐			
TPL.23.	Route work items and documents related to estate recovery claims and processes to appropriate estate recovery staff	☐			
TPL.24.	Allow access to Estate Recovery cases to legal and other staff authorized by EOHHS on a case-specific basis	☐			
TPL.25.	Generate affidavit, estate and lien claims; voluntary receipt letters; follow-up letters; closing letters and documents; refund letters; and other necessary documents, using templates pre-populated with information from the estate recovery case management system	☐			
Casualty Recovery The FA will implement a Case Tracking tool with workflow functionality that supports Estate Recovery, including:					
TPL.26.	Initiate a Casualty Recovery case based on presence of a trauma procedure or diagnosis on an adjudicated claim. Automatically generate identification, tracking and follow-up notifications for claims with trauma diagnosis codes, accident codes, and indicators as defined by EOHHS.	☐			
TPL.27.	Update Casualty Recovery cases based on questionnaire, SWICA and other documents received	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TPL.28.	Provide the ability to store, retrieve, and update relevant program data, including member attorney and insurance company information and lien amounts and statuses	☐			
TPL.29.	Generate, track, and distribute member trauma reports as directed by the State	☐			
TPL.30.	Generate and send questionnaires to case-heads regarding possible trauma incidences to a member	☐			
TPL.31.	Provide the ability to generate, distribute, and track letters and invoices distributed to associated third parties regarding invoices	☐			
TPL.32.	Generate and send a certified, lien letter to involved attorney(s) and/or insurance company(s)	☐			
TPL.33.	Generate letters to SSA and the settlement provider acknowledging receipt of settlement	☐			
TPL.34.	Process worker's compensation activity file against Medicaid eligibility data to identify individuals receiving both Medicaid and workers compensation	☐			
TPL.35.	Provide the ability to store multiple incidences of a casualty based on the date and time of the occurrence within the casualty case management system.	☐			
Outputs					

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TPL.36	Letters and notices required for follow-up and settlement of Casualty and Estate cases. Examples include: SWICA letter, Casualty Questionnaire, Request for Additional Information, Notice of Case Amount Due, Estate Notice of Liability, Case Settlement Request, Lien Letter, Ad-hoc letters, and other letters to be determined by the State. Letters and notices to be added and changed via a flexible administrative module allowing production of letters and notices without hard coding.	☐			
TPL.37	Casualty and Estate Recovery case management reports as specified by EOHHS	☐			
TPL.38.	Claims mass adjustment reports	☐			
Interfaces					
TPL.39.	Provide automatic updates of verified TPL information through an interface to the eligibility system of record	☐			
TPL.40.	Implement an automated interface to receive TPL information from the child support enforcement system for Medical Assistance children with absent parent or other medical coverage	☐			
TPL.41.	Support an interface to transmit TPL information to and from the Welligent system for Early Intervention program and other system interfaces providing relevant TPL data	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TPL.42.	Automate interfaces with the Department of Motor Vehicles (DMV) and the Department of Labor and Training (DLT) for retrieval of casualty-related information	☐			
TPL.43.	Support an interface to the EOHHS Data Warehouse update third-party liability information from the MMIS	☐			
TPL.44.	Support an interface to the State's Legal Case System	☐			
Fiscal Agent Responsibilities					
TPL.45.	Implement a unique numbering system for Casualty Recovery cases and Estate Recovery cases created in case tracking tool for use with outgoing and incoming correspondence, and reports	☐			
TPL.46.	Establish a document library for storing case documentation, indexed by unique numbering system	☐			
TPL.47.	Scan and image all correspondence received in relation to Casualty and Estate Recovery cases. Link scanned documents to case IDs in the Case Tracking tool.	☐			
TPL.48.	Archive all correspondence generated in document library, indexed by unique numbering system	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TPL.49	Systemically generate letters requested for each case, and mail them using any special letter instructions defined by the State (e.g., certified mail for lien notices)	☐			

6.2.3. Detailed Requirements – Program Integrity

The FA will support enhancement of program integrity efforts through improved tracking of identified SURS cases using a Case Tracking tool.

Bidder acknowledges and accepts responsibility for the following requirements as indicated by checking the box in the column “Bidder Acknowledgment.”

Functional requirements for enhancements are presented in table format below. Complete checklists are included in Appendix O.1 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 25: Requirements for Program Integrity

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
Inputs					
PI.1.	Imaged or scanned documents or attachments to SURS cases tracked in the Program Integrity Case Tracking tool	☐			
PI.2.	Online updates to the tool by authorized users	☐			
Processing					
Provide a Program Integrity Case Tracking tool that allows the creation and assignment of SURS cases. Additional functionality specific to Program Integrity includes the following:					
PI.3.	Provide the ability to enter complaints and referrals from outside parties and agencies about members or providers into an electronic tracking system for fraud and abuse investigations	☐			
PI.4.	Apply and track payments received from providers	☐			
PI.5.	Establish payment arrangements for settled cases	☐			
PI.6.	Link current and historical member IDs to track and retrieve all services to a single member regardless of the number of historical changes in member ID	☐			
PI.7.	Link current and historical provider data, including group provider data, to capture all the entities under which one provider may be affiliated	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
PI.8.	The Case Tracking System must be deployed on the Web Foundation. (See Technical Requirements, Section 7 of this RFP)	☐	N/A		
PI.9.	The Case Tracking System must be integrated with the other applications through the ESB. (See Technical Requirements, Section 7 of this RFP)	☐			
Outputs					
PI.10.	Letters and notices required to follow-up on SURS cases. Examples include: Request for Additional Information, Claims History Reports, Ad-hoc letters, Lien Notices and other letters to be determined by the State.	☐			
PI.11.	Generation of a MMIS claims adjustment file for mass adjustment of claims when a case is settled	☐			
PI.12.	Accounts receivables reporting for settled cases	☐			
Interfaces					
The Program Integrity Case Tracking tool will support interfaces with the following systems:					
PI.13.	MMIS	☐			
PI.14.	EOHHS Data Warehouse	☐			
PI.15.	Legal Case System (PROCATS)	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
PI.16.	RIFANS	☐			
Fiscal Agent Responsibilities					
PI.17.	Implement a unique numbering system for all SURS cases created in the Program Integrity Case Tracking tool for use with outgoing and incoming correspondence and reports	☐			
PI.18.	Establish a document library for storing case documentation, indexed by unique numbering system	☐			
PI.19.	Scan and image all correspondence received in relation to identified SURS cases. Link scanned documents to case IDs in the Case Tracking tool.	☐			
PI.20.	Archive all correspondence generated in document library, indexed by unique numbering system	☐			
PI.21.	Systemically generate letters requested for each case, and mail them using any special letter instructions defined by the State (e.g., certified mail for lien notices)	☐			

6.3. Customer Service Requirements

This section includes a narrative description and detailed requirements for enhanced Customer Services.

6.3.1. Narrative Description

High-level requirements for Customer Service include the following enhancements identified in the APD:

Develop an automated call tracking system

The FA will establish and maintain a Provider Call Center with the following capabilities:

- Improve Provider Call Center processes by implementing an automated call tracking system to manage and report on calls from providers and clients; and
- Support Provider Call Center staff and processes through MMIS centralized software as specified by EOHHS.

The FA is required to staff a Provider Call Center to meet the performance requirements included in this document. EOHHS may decide to provide supplemental staff for the Provider Call Center on an occasional or permanent basis. The FA will be required to meet all requirements without consideration for possible staffing by the State.

6.3.2. Detailed Requirements

This section includes detailed requirements for the customer service enhancements to the MMIS. The requirements are organized as:

- Inputs
- Processing
- Outputs
- Interfaces
- FA Responsibilities

Bidder acknowledges and accepts responsibility for the following requirements as indicated by checking the box in the column “Bidder Acknowledgment.”

Functional requirements for enhancements are presented in table format below. Complete checklists are included in Appendix O.1 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 26: Requirements for Customer Service

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
Inputs					
CS.1.	Telephone calls from in-state and out-of-state providers of Medicaid, Global Waiver, CNOM and other medical services processed through the MMIS	☐	N/A		
Processing The State is asking Bidders to propose a Commercial Off the Shelf (COTS) or transfer application for Provider Call Center tracking software. Desired functionality is detailed in this document and will be evaluated as part of the selection process. Desired functionality includes the following requirements:					
CS.2.	Enhance Provider Call Center functionality by implementing improved automated call distribution and tracking software with the ability to record and aggregate information designated by EOHHS by line as detailed in Section 2.4 of this RFP. Specific functionality will be proposed by Bidders and finalized in the design sessions.	☐			
CS.3.	Include functionality to track basic call information entered automatically or by Provider Call Center staff, including date and time of call, caller name, caller company/employer, reason for call, resolution of call, and FA staff person ID. Specific functionality will be proposed by Bidders and finalized in the design sessions	☐			
CS.4.	Maintain a detail history of Provider Call Center calls for up to three (3) years	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.5.	Track grievances and appeals by providers and members initiated or followed up through the Provider Call Center	☐	N/A		
CS.6.	The Call Center Tracking System must be deployed on the Web Foundation. (See Technical Requirements, Section 7 of this RFP)	☐			
CS.7.	The Call Center Tracking System must be integrated with the other applications through the ESB. (See Technical Requirements, Section 7 of this RFP)	☐			
Outputs					
CS.8.	Maintain required Provider Call Center statistics and report to EOHHS on a daily, weekly and monthly basis or according to the reporting schedule and format specified by EOHHS. Desired statistics are: Number of incoming calls	☐			
CS.9.	Total number of calls answered by each staff member	☐			
CS.10.	Average number of calls answered by each staff member	☐			
CS.11.	Average call wait time by staff member	☐			
CS.12.	Average talk time by staff member	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.13.	Percent of calls answered by each staff person and cumulative FA staff in less than 30 seconds after selection of menu option during normal business hours, segregated as specified by EOHHS by such categories as routine and authorization services calls	☐			
CS.14.	Maintain the capability to differentiate statistics for State and FA Provider Call Center staff as well as individual staff	☐			
CS.15.	Produce and deliver weekly reports, providing the following: Produce standard reports on call completion statistics as specified by EOHHS. Reports will include data such as: number of attempts, completions, retries, average minutes holding time, average length of calls, number of calls receiving busy signals, number of abandoned calls. Provide data by one hour intervals or as specified by EOHHS.	☐			
Interfaces					
CS.16.	Maintain an interface with the MMIS for inquiry and update by authorized Provider Call Center staff	☐	N/A		
Fiscal Agent Responsibilities					
Location and Staffing Requirements					

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.17.	Maintain and operate an integrated Provider Call Center that incorporates all Provider Call Center activities under the contract	☐	N/A		
CS.18.	Staff a Provider Call Center with highly trained personnel who are able to provide quality service and assistance to the Rhode Island Medical Assistance Program community, including providers, members and contracting agencies	☐			
CS.19.	Ensure Provider Call Center telephone staff has at least two years of medical claims examination/billing experience and good customer service skills	☐			
CS.20.	Locate a Provider Call Center within 20 miles of Medical Assistance offices in Cranston, Rhode Island for access by up to 10 State staff. Provider Call Center personnel may be located at various sites as long as call tracking and timeliness requirements are met through automation.	☐			
CS.21.	Provide sufficient toll-free lines, all necessary telephone system infrastructure and support, and maintain toll-free business lines for the Provider Call Center to meet performance requirements	☐			
CS.22.	Develop and adhere to a contingency plan for temporary or permanent increases in volumes of calls	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.23.	Staff the Provider Call Center as required to meet performance requirements defined in Appendix J to this RFP	☐			
CS.24.	Staff the Provider Call Center to meet performance requirements from 8:00 AM to 5 PM ET, Monday through Friday on State work days	☐			
CS.25.	Staff the Provider Call Center to meet performance requirements after hours, weekends and holidays	☐			
CS.26.	After regular business hours, provide an automated message system to collect caller information (e.g., voice mail)	☐			
CS.27.	Provide Provider Call Center staff or translation services for the following languages: Spanish	☐			
CS.28.	Provide a translation service with immediate (within 60 seconds) access to services during normal working hours	☐			
Procedures, Training and Quality Control					
CS.29.	Perform quality control on Provider Call Center staff by listening to line calls or recorded calls on a weekly basis. Report results to EOHHS in a format specified by EOHHS	☐	N/A		
CS.30.	Develop a training curriculum for the Provider Call Center staff for review and approval by EOHHS, and implement the approved curriculum	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.31.	Develop and maintain current procedures for Provider Call Center staff to respond to all provider inquiries such as covered health program billing procedures and issues, claim status, system problems, prior authorizations, payment issues and general questions regarding policy and regulations. Include specific procedures for Pharmacy POS assistance as directed by EOHHS	☐			
CS.32.	Refer inquiries, which cannot be answered immediately by the Provider Call Center staff, to the appropriate EOHHS staff as designated in documented procedures	☐			
Reliability Requirements					
Ensure the Provider Call Center downtime does not exceed one-half hour for any given month. In the event of system failure the Contractor shall:					
CS.33.	Notify EOHHS (via e-mail or telephone) of any incident of Provider Call Center downtime within one-half hour of the incident, or as soon as the FA is aware of the interruption. Provide the cause and projected duration of the incident as soon as it is known	☐	N/A		
CS.34.	Notify providers via the Web portal of any incident of down time as directed by EOHHS	☐			
CS.35.	Report closure measures and corrective actions within twenty-four hours of systems repair, including the actual cause, areas impacted, corrective actions and preventive measures	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.36.	Provide an electronic notice to EOHHS and online users of any planned system interruption, shutdown or lost file access at least three workdays prior to the system interference. Provide notice to providers through the Web portal at the same frequency or as specified by EOHHS.	☐			
Pharmacy POS Assistance					
CS.37.	Provide prior authorization services in support of the Pharmacy POS system, including DHS, BHDDH and DOE claims according to the criteria specified by EOHHS	☐			
Performance Requirements					
EOHHS has specified the following performance requirements for the Provider Call Center:					
CS.38.	Answer 90% of routine calls within 30 seconds during normal working hours. Normal working hours are defined as 8 AM to 5 PM ET, Monday through Friday, excluding State holidays.	☐	N/A		
CS.39.	Answer 95% of routine calls within 45 seconds during normal working hours	☐			
CS.40.	Answer 99% of routine calls within 60 seconds during normal working hours	☐			
CS.41.	Answer or route to voice mail 90% of routine calls within 20 seconds after hours, weekends or holidays	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.42.	Ensure that the weekly average number of incoming calls that are blocked (calls receiving a busy signal) shall be no more than one percent	☐			
CS.43.	The weekly average abandon rate shall be no more than five percent. A call will be considered abandoned after the first thirty seconds when a caller chooses to disconnect after the introductory message and prior to being connected to a staff member or voice mail.	☐			
CS.44.	The weekly average wait or hold time shall not exceed one-hundred twenty seconds	☐			

6.4. Claims Processing Requirements

The section includes a narrative description and detailed requirements for enhanced Claims Processing.

6.4.1. Narrative Description

The MMIS will be modified to process additional claims, including claims for services under EOHHS programs, Global Waiver programs, CNOMs, and specified claims for other agency, medical, and health services programs, including BHDDH, DOH, DCYF, and DOC.

The FA will be required to process additional claims for EOHHS and its sister agencies through the MMIS. All claims transactions will be in standard HIPAA formats. Claims will use the National Provider Identifier (NPI) solely as the provider ID, except in the case of atypical providers that are not eligible for an NPI. These providers will be enrolled as Medicaid providers and assigned a provider ID number. Standard medical data codes sets (i.e., procedure and diagnoses codes) will be used for all claims processing. Standard reimbursement methodologies will be used in general. EOHHS may, during the project develop additional payment methodologies to support national and State initiatives, such as medical homes, pay-for-performance, incentives, etc. Multiple methodologies may apply to a single provider, depending on the client characteristics and the services provided.

Eligibility will be input and maintained in the MMIS through one of the current methods. Each agency will establish appropriate automated edits and authorization processes as well as business rules for processing suspended and denied claims.

This document lists new claims processing requirements identified through sessions with EOHHS and other agency users. Additional CNOM, waiver, and other programs may be developed or identified during the procurement time frame. It is expected that the FA will process claims for all such programs identified by EOHHS. EOHHS may also decide to eliminate processing of claims for certain programs, CNOMs or waivers. Complete requirements will be finalized during the design sessions.

The FA will enhance the MMIS to automate patient liability processing for specified programs and waivers. Use of lump sum payments for services will be eliminated or reduced. EOHHS will designate those programs whose claims will be processed through the MMIS and lump sum payments that will be eliminated during the design sessions.

6.4.2. Detailed Requirements

This section includes detailed requirements for the claims processing enhancements to the MMIS. The requirements are organized into the following sections:

- General Requirements
- Inputs
- Processing
- Outputs
- Interfaces
- FA Responsibilities

Bidder acknowledges and accepts responsibility for the following requirements as indicated by checking the box in the column “Bidder Acknowledgment.”

Functional requirements for enhancements are presented in table format below. Complete checklists are included in Appendix O.2 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 27: Requirements for Claims Processing

ID	EOHHS Requirement	Bidder Acknowledgment
Inputs		
CLM.1.	Additional claims transactions submitted in standard HIPAA formats (including ASC X12 5010 claims transactions and National Council for Prescription Drug Programs (NCPDP) D.0)	☐
CLM.2.	Additional prior authorization transactions submitted in standard HIPAA format by agencies or providers, or real-time authorizations generated by the Care Management System, including modifications to DCYF prior authorization transactions and acceptance of authorizations from programs administered by DHS, BHDDH and DOH such as Shared Living, Community and Assisted Living Programs, etc.	☐
CLM.3.	Prior authorizations in standard HIPAA format submitted by providers through the provider Web portal	☐
CLM.4.	Claims with attachments in standard HIPAA format (when rule is finalized) submitted by providers through the provider Web portal	☐
CLM.5.	DCYF member data from RICHIST to support accurate federal reporting, such as trust, IV-E, Individual Education Plan (IEP), personal care and child support information	☐
CLM.6.	Primary Care Physician data from the managed care plans entered through the Web portal or other automated input in proprietary format as specified by EOHHS	☐
CLM.7.	Minimum Data Set (MDS) records received from DOH or the EOHHS Data Warehouse to support RUG pricing	☐
Processing		
General Enhanced Claims Processing		
CLM.8.	Process additional claims transactions for State agencies in standard HIPAA formats including billing and rendering provider IDs as directed by EOHHS	☐
CLM.9.	Process claims for additional CNOMS, waivers and agency programs, including Adaptive Telephone Equipment, Breast and Cervical Cancer Treatment Program (BCCTP) screenings, Developmentally Disabled (DD) Day and Supported Employment, Substitute Care, all Residential Diversion programs, Reunification Support, Substance Abuse Non-IMD Residential, Substance Abuse Outpatient, Methadone, and other programs designated by EOHHS during design sessions	☐

ID	EOHHS Requirement	Bidder Acknowledgment
CLM.10.	Process claims identifying performing or rendering providers in addition to billing providers for programs such as Early Intervention, Community and Assisted Living Waivers and Nursing Home Transition Services, and other programs specified by EOHHS during design sessions	☐
CLM.11.	Process prior authorizations received through the provider Web portal and post results (accept, deny or pend) on the Web portal	☐
CLM.12.	Accept updates to pended prior authorizations received through the provider Web portal, process updates and determine outcomes, and post results	☐
CLM.13.	Process claims with attachments received through the provider Web portal, automatically link attachments to claims, and post results (accept, deny or pend) on the Web portal	☐
CLM.14.	Generate and distribute Medicare premium payments as specified by EOHHS	☐
CLM.15.	Accept (according to EOHHS-approved methods) and post received Medicare premium payments, and issue notifications of past due payments. Disenroll clients missing payments according to EOHHS-specified criteria.	☐
CLM.16.	Process claims according to new reimbursement methodologies as directed by EOHHS to support national and State initiatives. Examples include methodologies to support medical homes, ACA provisions, payment for performance, incentive payments, etc.	☐
CLM.17.	Allow payment of a single provider through multiple methodologies, depending on client characteristics and services provided	☐
DCYF Claims Processing		
CLM.18.	Process DCYF claims, and assign the appropriate funding source according to hierarchy established by EOHHS	☐
CLM.19.	Process DCYF claims for residential providers at provider-specific rates, which are maintained in the MMIS. Pay lead agency (billing) providers at rates specific to rendering providers.	☐
CLM.20.	Continue to process DCYF claims for community-based services providers by Healthcare Common Procedure Coding System (HCPCS) procedure	☐
CLM.21.	Pay designated DCYF claims at 100 percent of billed rates	☐

ID	EOHHS Requirement	Bidder Acknowledgment
CLM.22.	Process CNOM claims for Residential Diversion and Reunification Support programs, and designate the appropriate funding source	☐
BHDDH Claims Processing		
CLM.23.	Process claims for the Methadone and Substance Abuse Outpatient programs, including billing and performing providers, based on HCPCS procedure codes	☐
CLM.24.	Process claims for Substance Abuse Non-IMD residential providers	☐
CLM.25.	Process claims for DD Day and Supported Employment program claims as directed by BHDDH and EOHHS	☐
DHS's DEA Division Claims		
CLM.26.	Process claims for CNOMS, Elderly Population Transportation, Assisted Living and Home Care, and other DEA Division programs	☐
DOH Claims		
CLM.27.	Automate designation of the funding source for ADAP and ADAP CNOM program claims processed through the MMIS	☐
CLM.28.	Process claims for the Women's Cancer Screening Program	☐
DHS Nursing Home Claims		
CLM.29.	Provide the ability to process electronic nursing home claims in standard HIPAA format, including editing, adjudication and payment, based on member-specific RUG score billed on inpatient residential facility (e.g., LTC) claims	☐
CLM.30.	Provide the ability to generate case mix index information to be used for rate setting purposes and for distribution to providers as directed by the State for residential care, nursing facilities, LTC providers, and other LTC services	☐
CLM.31.	Maintain pricing data based on RUGs	☐
CLM.32.	Identify, distinguish, and maintain interim, final or multiple residential facilities (e.g. LTC) rates per provider or provider ID as directed by EOHHS	☐

ID	EOHHS Requirement	Bidder Acknowledgment
CLM.33.	Maintain MDS case mix information received from residential care facilities	☐
Pharmacy Point-of-Sale		
CLM.34.	Continue to process pharmacy claims for DOH (ADAP), DHS/DEA (RIPAE) and BHDDH (CMAP), and expand processing for additional programs as requested by EOHHS	☐
CLM.35.	Support NCPDP D.0 standards for pharmacy point-of-sale electronic transactions	☐
Provider Web Portal		
CLM.36.	Enhance the provider Web portal to accept electronic prior authorizations and claims with attachments	☐
Support of National Initiatives		
CLM.37.	Implement ICD-10 functionality/crosswalk to support billing, processing/editing, and payment of claims with ICD-10 code set	☐
CLM.38.	Modify MMIS to support editing and adjudication of claims and prior authorization requests based on diagnosis and procedure code matching upon implementation of ICD-10 code set and other measures specified by EOHHS	☐
CLM.39.	Modify the MMIS system and supporting inputs and outputs, to use the National Provider Identifier as the primary Provider key. Unique identifier information should include, but is not limited to: all practice locations, provider types, specialties, authorization/enrollments/licensing for services, and all other appropriate information for that provider as a logical record linked to the one provider number.	☐
CLM.40.	Assign unique provider identification numbers to non-NPI (atypical) providers as specified by EOHHS	☐
Outputs		
CLM.41.	Updates to the Care Management System of claims submitted, pended and adjudicated, indicating the MMIS as the data source on a schedule specified by EOHHS. Claims information will include dates of service, member ID, billing and performing provider IDs, procedures, diagnoses and other data specified by EOHHS during the design sessions.	☐

ID	EOHHS Requirement	Bidder Acknowledgment
CLM.42.	Updates to the Care Management System of prior authorizations submitted, pended, and approved, indicating the MMIS as the data source on a schedule specified by EOHHS. Prior authorization information will include dates of service, member ID, billing and performing provider IDs, procedures, amounts, types of service and other data specified by EOHHS during the design sessions.	☐
CLM.43.	Enhanced financial information on claims records to support automated federal and State reporting as described in Section 5 of this RFP	☐
CLM.44.	Adjudicated claims data for payment processing through the State financial system	☐
CLM.45.	Adjudicated claims data for additional claims for inclusion in MMIS history and the EOHHS Data Warehouse	☐
CLM.46.	Adjudicated claims data for inclusion on provider remittance advices and 835s	☐
CLM.47.	Claims financial data to EOHHS finance staff for appropriate claiming and reporting	☐
CLM.48.	Premium processing financial data to EOHHS finance staff for appropriate claiming and reporting	☐
CLM.49.	Capitation payment data to EOHHS finance staff for appropriate claiming and reporting	☐
CLM.50.	Standard reports specified by EOHHS (to be defined at a high level), which will be defined during the design sessions	☐
Interfaces		
CLM.51.	Implement a LTC interface between the source of the MDS version 3 (MDS 3.0) and the MMIS for the purposes of establishing RUG rates for provider reimbursement	☐
CLM.52.	Implement an interface with the Care Management System to receive prior authorizations from the CMS, update the CMS with claims and encounter data, prior authorizations and issue alerts, sanctions, eligibility flags, etc., as specified by EOHHS	☐
CLM.53.	Maintain and enhance the interface with RIFANS to support automation of federal and State reporting, and allocation of claims, premiums, capitation payments and other financial transactions processed through the MMIS	☐

ID	EOHHS Requirement	Bidder Acknowledgment
CLM.54.	Develop and maintain interfaces between the MMIS and RIFANS with the Medicaid budget forecasting model	☐
Fiscal Agent Responsibilities		
CLM.55.	Receive, control, edit and adjudicate claims for agencies' programs specified by EOHHS	☐
CLM.56.	Enroll providers and maintain provider information for billing and rendering providers designated by the agencies, including atypical providers	☐
CLM.57.	Maintain provider-specific rates for DCYF billing and performing providers	☐
CLM.58.	Maintain MDS case mix information received from residential care facilities through DOH or the EOHHS Data Warehouse	☐
CLM.59.	Generate standard reports not produced by the EOHHS Data Warehouse	☐
CLM.60.	Maintain report distribution reports, including persons receiving reports and frequency of production	☐

6.5. Eligibility (Beneficiary Management Requirements)

This section includes a narrative description and detailed requirements for enhanced Eligibility (Beneficiary Management) processing.

6.5.1. Narrative Description

High-level requirements for Eligibility Determination and Maintenance include the following enhancements identified in the APD:

Maintain Member Eligibility Information

- Create, accept, and maintain accurate, current, and historical record of eligibility and demographic information; and
- Support eligibility verification, ID card production, claims and premium processing, cost avoidance (including TPL), SSI benefit payment production and management reporting.

The MMIS currently receives beneficiary enrollment data from the following sources:

- A daily batch process with the State's eligibility system, InRhodes;
- Excel spreadsheets that are sent to a secure File Transfer Protocol (FTP) site; and
- A proprietary software program from the current FA that updates MMIS eligibility data.

Rhode Island is currently in the process of procuring a contract to support the implementation of a State-based Health Insurance Exchange required by the ACA. This contract is expected to be a phased implementation with the following scope and timeline:

- Phase I – The first phase of implementation will provide a system that can process applications based on the new Modified Adjusted Gross Income rules for determining an applicant's eligibility for Exchange-based premium subsidies, Medicaid, and (potentially) the Basic Health Program into an eligibility rules engine by July 2013.
- Phase II – Once the Exchange is up and running by January 2014 and the new eligibility system is operating efficiently and effectively, EOHHS will incorporate the eligibility determination rules for the more complex Medicaid programs into the eligibility engine with a target date of February 2015, but no later than December 2015.
- Phase III – Rhode Island will eventually seek to incorporate all of the remaining non-Medicaid programs into the rules engine. Target date TBD.

The FA will be required to support changes to the eligibility data feed to the MMIS as a result of Phase I and Phase II including full testing and documentation of changes. Costs associated specifically with these changes are outside the

scope of this RFP and will be handled through a separate contract, modification request, or change order.

6.5.2. Detailed Requirements

This section includes detailed requirements for the beneficiary management enhancements to the MMIS. The requirements are organized as:

- Inputs
- Processing
- Outputs
- Interfaces
- FA Responsibilities

Bidder acknowledges and accepts responsibility for the following requirements as indicated by checking the box in the column “Bidder Acknowledgment.”

Functional requirements for enhancements are presented in table format below. Complete checklists are included in Appendix O.2 to the RFP. Bidders must complete the checklists and include them in the proposal.

Table 28: Requirements for Eligibility

ID	EOHHS Requirement	Bidder Acknowledgment
Inputs		
The MMIS will accept the following additional inputs. Note that eligibility will be input through one of the current methods for direct entry into the MMIS.		
ELG.1.	Member-specific data from RIDE (transportation program for elderly and adults with disabilities) to support non-emergency transportation claims processing and Medicare premium information from the Care Management System	☐
ELG.2.	Eligibility information for the following programs: BCCTP, Developmental Disabilities Day and Supported Employment CNOM, Substitute Care CNOM, all Residential Diversion, Reunification Support CNOM, Substance Abuse Non-IMD Residential, Substance Abuse Outpatient, Methadone, and other programs designated by EOHHS during design sessions	☐
ELG.3.	DCYF member data from RICHIST to support accurate State and federal reporting, such as trust, IV-E, IEP, personal care and child support information	☐
ELG.4.	Additional or modified data from InRhodes during implementation of Phases I and II of the State's new eligibility system. Modify the MMIS interface to accurately and receive and process data.	☐
Processing		
ELG.5.	Add Elderly Population Transportation eligibility indicator to member record in MMIS based on applicable eligibility category code or enrollment segment for DEA Adult Day Care and Home Health CNOMs	☐
ELG.6.	Add Early Intervention (EI) eligibility indicator to member record in MMIS based on EI eligibility segment from State's eligibility system, InRhodes	☐
ELG.7.	Enhance the current claims edit check on age restrictions for EI claims to include the new EI indicator	☐
ELG.8.	Add a SPMI program indicator to the member record in MMIS based on the eligibility criteria defined by BHDDH	☐
ELG.9.	Provide online, updatable letter templates for member letters with the ability to add free-form text specific to a member	☐
ELG.10.	Provide member information needed to support the new Care Management application	☐

ID	EOHHS Requirement	Bidder Acknowledgment
ELG.11.	Maintain eligibility information for the Adaptive Telephone Equipment CNOM	☐
ELG.12.	Maintain eligibility information for all waiver and CNOM programs identified in this RFP as well as additional programs identified in the design sessions	☐
ELG.13.	Maintain eligibility information for the MA member to remain in Rltc Care under the Reunification Support CNOM after Medicaid eligibility is discontinued according to the State's eligibility system, InRhodes. Add a DCYF wrap-around service indicator to the member record in the MMIS based upon applicable eligibility criteria. Allow wrap-around services (fee-for-service carve outs) to continue to be paid once DCYF member returns to standard MA eligibility.	☐
ELG.14.	Maintain eligibility for the ADAP CNOM program. Differentiate between the standard ADAP and ADAP CNOM programs	☐
ELG.15.	Automate the eligibility determination for the Women's Cancer Screening CNOM	☐
ELG.16.	Add a BCCTP recertification date to member eligibility record in the MMIS	☐
ELG.17.	Allow for Respite eligible members to continue to show Respite Program eligibility until age 21 when LTC eligibility segment begins. Automatically discontinue eligibility for Respite programs when the child reaches age 21.	☐
ELG.18.	Automate the tracking and deduction of patient liability (LTC client share) for the following programs. Incorporate logic into the MMIS to automatically determine which provider is responsible for collecting client share when more than one provider bills. Assisted Living	☐
ELG.19.	Personal Choice	☐
ELG.20.	Habilitation	☐
ELG.21.	PACE	☐
ELG.22.	DHS's DEA Adult Day Care CNOM (copay)	☐

ID	EOHHS Requirement	Bidder Acknowledgment
ELG.23.	DHS's DEA Home Care CNOM (copay)	☐
ELG.24.	Other long-term care programs as needed	☐
Affordable Care Act (ACA)		
Implement the new mandatory Medicaid Eligibility categories defined by the ACA		
ELG.25.	Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents) with income at or below 133 percent of the FPL beginning January 1, 2014	☐
ELG.26.	As of January 1, 2014, modify the MMIS to support the change in the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL	☐
ELG.27.	If RI decides to offer the Basic Health Program, eligible individuals would also include residents with income between 133% and 200% of the FPL	☐
Outputs		
ELG.28.	Enhanced extracts provided to the Human Resources Data Warehouse to include additional member data requirements	☐
ELG.29.	Online inquiry screens to display Medicare premium information, medical home information, transportation, waiver and CNOM eligibility, including historical eligibility dates as specified by EOHHS during design sessions	☐
Interfaces		
ELG.30.	The new Care Management application	☐
ELG.31.	The new Case Tracking application for program integrity, estate recovery, and casualty cases	☐
ELG.32.	An interface with RICHIST to access additional member information, such as trusts, IV-E eligibility, etc. needed for accurate accounting and financial reporting	☐
ELG.33.	Interfaces and functionality for the MMIS to interact with the Health Insurance Exchange and Health Information Exchange	☐
Fiscal Agent Responsibilities		

ID	EOHHS Requirement	Bidder Acknowledgment
ELG.34.	Receipt of data from new sources identified in Section 2.1.1 of this RFP	☐
ELG.35.	Maintenance of member data with modifications indicated in Section 2.1.2 of this RFP	☐
ELG.36.	Production of reports and outputs as defined in Section 2.1.3 of this RFP	☐
ELG.37.	Reconciliation of member data against source databases and the EOHHS Data Warehouse as directed by EOHHS	☐

6.6. Managed Care Requirements

This section includes a narrative description and detailed requirements for enhanced Managed Care processing.

6.6.1. Narrative Description

This section includes a narrative description of the high-level requirements to support enhanced managed care enhancements. Functionality includes managed care enrollment, MCO interfaces, and primary care case management.

High-level requirements for Managed Care include the following enhancements identified in the APD:

Enhance the Collection and Processing of Encounter Data

EOHHS will improve the quality of encounter data collected from the MCOs through modification of MMIS encounter data processing. Encounter processing will enforce HIPAA standards for all data and interfaces. The NPI solely will be used in encounter data and interfaces. In addition, the MMIS will be modified to process adjustments of encounter data.

The following requirement is included to support enhancement of coding to be used on all encounters:

Implement Functionality to Support National Initiatives

The MMIS will be modified to meet federal requirements including ANSI X12 5010 transactions, ICD-10 code set, support of Health Insurance Exchange, National Provider ID, etc. It will support the provisions of the ACA to achieve compliance deadlines.

The FA will accept, edit and maintain encounter data received from managed care contractors for Rite Care (including Rite Share), Rhody Health Partners and Rite Smiles. The FA will also accept proprietary format files from the managed care contractors containing information on primary care or performing providers, member specific indicators or information to support national and State initiatives, and other data specified by EOHHS.

The FA will be required to support additional managed care programs including enrollment and encounter processing if the number of contractors is increased or if EOHHS develops additional managed care programs. All encounter submissions will be in standard 5010 format.

Current managed care processing includes the following contractors:

- Rite Care (including Rite Share), contracted to the two managed care plans;
- Rite Smiles (Prepaid Ambulatory Health Plan), contracted to the Dental Benefits Manager; and
- Rhody Health Partners, contracted to two managed care plans.

The FA will continue to generate Rlte Share premium payments to qualifying members or their employers and incorporate modifications needed to support required enhancements. The FA will collect co-pay premiums owed by Rlte Care clients, maintain accounts receivable, and provide that information to the eligibility system through an interface according to documented procedures.

The FA will provide enhanced encounter data to the EOHHS Data Warehouse and Care Management System, and provide reports from the MMIS encounter data when necessary. The FA will display encounter information by member and provider to authorized users. Detailed requirements are specified in the following sections.

6.6.2. Detailed Requirements

This section includes detailed requirements for the managed care enhancements to the MMIS. The requirements are organized as:

- Processing
- Outputs
- Interfaces
- FA Responsibilities

Bidder acknowledges and accepts responsibility for the following requirements as indicated by checking the box in the column “Bidder Acknowledgment.”

Functional requirements for enhancements are presented in table format below. Complete checklists are included in Appendix O.2 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 29: Requirements for Managed Care

ID	EOHHS Requirement	Bidder Acknowledgment
Inputs		
The FA will accept the following inputs to support enhancements to the managed care functions through EDI or the provider Web portal:		
MC.1.	Eligibility transactions (enrollments, re-enrollments, disenrollments and reinstatements) from the eligibility system of record (now InRhodes) as documented in the MMIS Systems Documentation	☐
MC.2.	Encounter data in HIPAA 5010 format from the managed care plans for Rite Care (including Rite Share) and Rhody Health Partners and from the Rite Smiles Dental Benefits Manager	☐
MC.3.	Premium copay data from the eligibility system of record	☐
MC.4.	Monthly provider data in proprietary format, including participating provider data and primary care provider assignments, from the managed care contractors using NPI as the provider ID	☐
MC.5.	A monthly proprietary file including drugs and J-code procedures provided by managed care contractors and are eligible for rebate	☐
Processing		
Enrollment Maintenance Requirements		
MC.6.	Process enrollments, re-enrollments, disenrollments and reinstatements based on data received from the eligibility system of record	☐
MC.7.	Maintain program indicators based on eligibility data and criteria specified by EOHHS, such as Communities of Care incentive indicators, specific conditions (health-acquired) or other program indicators	☐
MC.8.	Generate day-specific enrollment, re-enrollment, disenrollment and reinstatement transactions to Rite Care managed care plans using approved HIPAA transactions in 834 format on a daily basis or as specified by EOHHS	☐
MC.9.	Generate day-specific enrollment, re-enrollment, disenrollment and reinstatement transactions to Rhody Health Partners and the Dental Benefits Manager for Rite Smiles using approved HIPAA transactions in 834 format on a daily basis or as specified by EOHHS	☐
MC.10.	Investigate rejected enrollment transactions and coordinate updates of the MMIS and the eligibility system of record as necessary to reconcile information in all systems according to procedures specified by EOHHS	☐
Encounter Processing Requirements		

ID	EOHHS Requirement	Bidder Acknowledgment
MC.11.	The FA will support processing of encounters and adjustments to encounters in standard HIPAA 5010 format. The FA will be required to support additional encounter processing if the number of contractors is increased or if EOHHS develops additional managed care programs.	☐
MC.12.	Receive and process encounter transactions from Rlte Care (including Rlte Share) and Rhody Health Partners managed care organizations and the Rlte Smiles Dental Benefits Manager in HIPAA 5010 format on a monthly basis or as specified by contract	☐
MC.13.	Edit encounter transactions according to criteria specified by EOHHS in design sessions. Determine if the encounter data is timely, accurate, complete, and complies with program policy.	☐
MC.14.	Edit encounters to ensure that performing and referring providers are identified on standard transactions using the NPI unless otherwise specified by EOHHS	☐
MC.15.	Edit NPIs for performing providers on encounter data against provider data supplied by the managed care contractors through a proprietary file or through the provider Web portal to verify provider participation with the managed care contractor	☐
MC.16.	Reject and report rejected encounters to the submitting organization. Respond to organizations within five work days of data submission regarding encounter data submission errors	☐
MC.17.	Investigate rejected encounter transactions and coordinate update of the MMIS and the eligibility system of record as necessary to reconcile information in all systems according to procedures specified by EOHHS	☐
MC.18.	Maintain an online log of all encounter submissions and results	☐
MC.19.	Reject an entire batch of encounters if it fails the tolerance levels of submission edits as defined by the Department	☐
MC.20.	Retain a unique submission ID in individual records for accepted files, and return back to the submitter totals of encounters pended, rejected and accepted by provider by reason for pended or rejected encounters	☐
MC.21.	Allow adjustment of accepted encounter records using standard HIPAA 5010 transactions, according to procedures specified by EOHHS	☐
MC.22.	Provide the ability to track adjustments, corrections, and link adjusted encounters to the original encounter submission	☐
MC.23.	Accept and maintain data in a format specified by EOHHS to support national initiatives such as identification of health-acquired conditions, Communities of Care incentives, etc.	☐

ID	EOHHS Requirement	Bidder Acknowledgment
Rite Share Processing Requirements The FA will continue to perform Rite Share processing according to current MMIS Systems Documentation and incorporate modifications to support required modifications, including:		
MC.24.	Generate employer-sponsored insurance premiums to members or employers as directed by EOHHS	☐
MC.25.	Expand identification of TPL activity from the eligibility system, managed care contractors or other sources identified by EOHHS. Receive and process monthly TPL updates from managed care contractors.	☐
MC.26.	Share TPL data with the Rite Share Unit on a timely basis through procedures designated by EOHHS	☐
MC.27.	Interface with the Rite Share Access database as specified in MMIS Systems Documentation and as modified during design sessions	☐
MC.28.	Provide online access to 24 months of member premium data, including payments to employers/members and invoices issued, paid and outstanding for member cost share amounts	☐
Rite Care Premium Processing Requirements The FA will continue to process Rite Care premiums owed by members and implement modifications required to support required enhancements:		
MC.29.	Suppress monthly invoices for cases in which no address is known	☐
MC.30.	Interface with the eligibility system to ensure accurate and timely information is provided to support reporting of payments made, insufficient funds, etc.	☐
MC.31.	Track and report Premium Collection Accounts Receivable	☐
MC.32.	Maintain historical information on premium accounts receivable (up to 24 months)	☐
MC.33.	Maintain premium collection customer services through the Provider Call Center	☐
MC.34.	Maintain and support Premium Payment options as defined by EOHHS (credit, debit, ACH, cash payment sites, etc.)	☐

ID	EOHHS Requirement	Bidder Acknowledgment
MC.35.	Support new legislation which requires members to be disenrolled for a total of 4 months if the premium is not paid for two months. Disenrollment for 4 months will be enforced even if member pays past due premiums.	☐
MC.36.	Provide the ability to write-off premium payments due according to criteria specified by EOHHS. Generate write-off transactions including funding sources and submit to EOHHS Finance for processing and financial reporting.	☐
Other Requirements		
MC.37.	Display detailed encounter data and adjustments on member and provider displays in the MMIS, Care Management System, and the provider Web portal, including dates, billing and performing providers, member, procedures, diagnoses and charges if available	☐
MC.38.	Process rebates for pharmaceuticals and J-code procedures provided by managed care contractors	☐
Outputs The FA will produce standard reports and other outputs based on encounters received from the managed care contractors. EOHHS anticipates that the majority of reports based on encounters will be generated through the EOHHS Data Warehouse. In certain cases, the MMIS may be required to generate the reports. For example, reports on capitation or premium payments, accounts receivable and reports on pending or rejected encounters.		
MC.39.	Produce and distribute standard reports from encounter processing, enrollment and capitation data as specified by EOHHS	☐
MC.40.	Provide the ability for ad hoc reporting to cover queries against encounter data and all statistical information related to encounter submissions	☐
MC.41.	Produce standard and ad hoc reports from encounter data to support national and State initiatives, such as advanced medical homes, medically acquired conditions, HEDIS, CAPS and other efforts	☐
MC.42.	Generate and disseminate reports to EOHHS according to the report distribution list	☐
MC.43.	Provide automated reports of managed care contractors that do not resubmit corrected encounters within fifteen calendar days, or as required by the contract, and submit them to EOHHS on a weekly basis	☐
MC.44.	Provide reporting capabilities to cover submitted, accepted, rejected, corrected, and resubmitted encounter records	☐
MC.45.	Generate managed care payment transactions in 820 format on a monthly basis	☐

ID	EOHHS Requirement	Bidder Acknowledgment
MC.46.	Generate standard HIPAA 835 data and remittance advices to managed care organizations detailing premiums paid, including detail data on clients and time frames	☐
MC.47.	Provide monthly reports on rebates processed for pharmaceuticals and J-code procedures provided by managed care contractors	☐
Interfaces The FA will continue to support the following interfaces including modifications needed to support required enhancements:		
MC.48.	Maintain an interface with the eligibility system of record to support maintenance of eligibility and enrollment data for participation in Rhode Island's managed care programs	☐
MC.49.	Maintain an interface with the EOHHS Data Warehouse to provide updated encounters and adjustments, primary care and other provider data, member-specific indicators, and data on capitation and premium payments	☐
MC.50.	Maintain an interface with the RI Division of Taxation to perform Tax Intercept processing as documented in the MMIS Systems Documentation	☐
Fiscal Agent Responsibilities		
MC.51.	Maintain documentation of all contractors' performance of encounter data submission activities, including edit results, volume and consistency of submissions	☐
MC.52.	Designate and maintain sufficient dedicated staffing levels to support all functions of encounter data processing for managed care contractors	☐
MC.53.	Make recommendations to EOHHS when new technologies become more viable for data collection	☐
MC.54.	Provide technical assistance to the managed care contractors regarding encounter data submission activities including assisting contractors with instructions on how to submit encounter data. Review encounter data reports, and contact the appropriate contractors to discuss and assist with error and issue resolution. Provide training and assistance to new contractors on encounter data submission and test submission files.	☐
MC.55.	Reconcile fee-for-service claims against encounter data on an annual basis or at a frequency specified by EOHHS to identify duplicate or suspect duplicate payments for services to managed care clients	☐
MC.56.	Investigate and report duplicate payments made by EOHHS and recoup payments as directed by EOHHS	☐

ID	EOHHS Requirement	Bidder Acknowledgment
MC.57.	Accurately capture and retain encounter data for two years in the MMIS and without limitation in the EOHHS Data Warehouse	☐
MC.58.	Refresh encounter data in the EOHHS Data Warehouse with MMIS encounter data daily or at a frequency specified by EOHHS	☐
MC.59.	Accurately capture and maintain the encounter data and submission records in a database for reporting purposes. Maintain up to 60 months of historical data.	☐

6.7. Financial and Program Management Requirements

This section includes a narrative description and detailed requirements for enhanced Financial and Program Management processing.

6.7.1. Narrative Description

This section includes a narrative description of the high-level requirements to support enhanced financial and program management. Functionality includes federal reporting, program management reporting, financial management, decision support systems/data warehouse, and security and privacy.

High-level requirements for Financial and Program reporting include the following enhancements identified in the APD:

Improve Financial and Program Reporting

The MMIS will be modified to:

- Improve the automation of reports designed specifically to fulfill the requirements of the CMS 64, according to EOHHS specifications. Improvements will include, but will not be limited to, the reduction of lump-sum payments and other Fiscal Agent Change Notice (FACN) transactions designated by EOHHS. Processing additional claims through the MMIS will allow the MMIS to automatically report details on some transactions that are currently not claims-specific or client-specific. Claims-specific transactions will be available in the MMIS rather than separate databases and systems. The MMIS crosswalk with RI-FANS will be modified to streamline budget categories;
- Implement budget forecasting functionality, standard reports for programs and operations, and reporting against agency goals and initiative; and
- Implement automated rate-setting processes as specified by EOHHS, including, but not limited to, the maintenance of all current fee schedules.

This section includes detailed requirements for the financial and program management enhancements to the MMIS, including requirements for the EOHHS Data Warehouse, Federal Reporting, Program Reporting, Financial Reporting, and Security and Privacy.

6.7.2. Detailed Requirements – EOHHS Data Warehouse

The FA will maintain and operate the EOHHS Data Warehouse to support federal, program and financial standard and ad hoc reporting for DHS, DCYF, DOH, BHDDH and DOC.

The requirements are organized as:

- Inputs
- Processing

- Outputs
- Interfaces
- FA Responsibilities

Bidder acknowledges and accepts responsibility for the following requirements as indicated by checking the box in the column “Bidder Acknowledgment.”

Functional requirements for enhancements are presented in table format below. Complete checklists are included in Appendix O.2 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 30: Requirements for Financial and Program Management

ID	EOHHS Requirement	Bidder Acknowledgment
Inputs The FA will incorporate the following additional data sources into the EOHHS Data Warehouse:		
DW.1.	CNOM expenditure data to be incorporated into MMIS including the following CNOM data as well as any additional CNOMs identified by EOHHS during the design sessions: Community Health Centers	☐
DW.2.	Adaptive Telephone Equipment	☐
DW.3.	Transportation (RIDE)	☐
DW.4.	DD Day & Supported Employment	☐
DW.5.	Residential Diversion CBH	☐
DW.6.	Residential Diversion CW	☐
DW.7.	Residential Diversion Voluntary	☐
DW.8.	Reunification Support	☐
DW.9.	Women's Cancer (BCCTP) Screening	☐
DW.10.	Substance Abuse Non-IMD Residential	☐
DW.11.	Methadone	☐

ID	EOHHS Requirement	Bidder Acknowledgment
DW.12.	Substance Abuse Outpatient	☐
DW.13.	Managed care data from the MCOs incorporating additional data elements from the encounter (5010) transaction, PCP data and member-specific data received through proprietary files or the provider Web portal	☐
DW.14.	Additional claims data for claims processed through the MMIS as described in section 2 of this document	☐
DW.15.	Data currently stored in the RItE Share Access Database for performance measurement, such as employer information, benefits, open enrollment periods and premium payment information	☐
DW.16.	Health outcomes data currently used to measure performance, benchmarking and calculate outcome measures, such as: Public health databases	☐
DW.17.	Hospital discharge data	☐
DW.18.	Vital statistics	☐
DW.19.	National substance abuse data sources	☐
DW.20.	Quality metrics such as HEDIS	☐
DW.21.	Data from the Care Management System, including care plans and prior authorization data	☐
DW.22.	KIDSNET data, including immunization, hearing loss and lead screenings from DOH	☐
DW.23.	Lead paint, lead inspection, home visitation data, developmental risk assessments, newborn hearing assessments, newborn blood spot and audiology testing results and follow-up, birth defects, and other data from DOH identified by EOHHS during the design sessions	☐
DW.24.	BHDDH behavioral health data on case plans, assessments, services and TPL, as well as data on client admits, discharges and outcomes	☐

ID	EOHHS Requirement	Bidder Acknowledgment
DW.25.	Early Intervention Welligent data, including case plans, assessments, services and TPL	☐
DW.26.	DLT wage and unemployment insurance data	☐
DW.27.	RIDE data warehouse data (nutrition)	☐
DW.28.	DOC prison reentry and WINFACTS	☐
DW.29.	DCYF RICHIST data (selected data related to medical and behavioral health services)	☐
DW.30.	Encounter data from the Transportation Broker	☐
Processing		
DW.31.	Accept, edit and process new data from identified sources according to schedule defined by the EOHHS	☐
DW.32.	Produce standard and ad hoc reports as specified in this document and as otherwise defined by EOHHS during design sessions. (Note: examples of these reports or some limitations must be provided for the RFP.)	☐
Outputs		
DW.33.	Generate standard reports to support federal reporting as defined in Section 2.3	☐
DW.34.	Generate standard reports to support program reporting as defined in Section 2.4	☐
DW.35.	Generate standard reports to support financial reporting as defined in Section 2.5	☐
DW.36.	Provide ad hoc reporting by FA staff (Note: must define volume or limit.)	☐

ID	EOHHS Requirement	Bidder Acknowledgment
DW.37.	Support ad hoc reporting by authorized EOHHS and other agency staff and contractors	☐
Interfaces		
DW.38.	Interfaces necessary to support new data source requirements as specified in Section 2.2.1	☐
DW.39.	Interfaces necessary to support federal, program and financial reporting as specified in Sections 2.3, 2.4 and 2.5	☐
Fiscal Agent Responsibilities		
DW.40.	Maintain data and process updates on frequencies specified by EOHHS	☐
DW.41.	Produce reports on frequencies specified	☐
DW.42.	Maintain current system and user documentation throughout the term of the contract. Update documentation within 30 days of a change to the system.	☐
DW.43.	Maintain sufficient database specialists and system developers with skills to meet the requirements of this RFP	☐
DW.44.	Provide training to new users at least monthly for up to 30 users per month	☐
DW.45.	Provide refresher training sessions and training on new data and features for current users at least monthly for up to 100 users per month	☐
DW.46.	Refresh data on a schedule specified by EOHHS	☐

6.7.3. Detailed Requirements – Federal Reporting

The FA will be responsible for producing standard and ad hoc reports to support federal reporting.

The requirements are organized as:

- Inputs
- Processing
- Outputs
- Interfaces
- FA Responsibilities

Bidder acknowledges and accepts responsibility for the following requirements as indicated by checking the box in the column “Bidder Acknowledgment.”

Functional requirements for enhancements are presented in table format below. Complete checklists are included in Appendix O.2 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 31: Requirements for Federal Reporting

ID	EOHHS Requirement	Bidder Acknowledgment
Inputs The FA will receive and incorporate all program expenditures to automatically calculate federally mandated reports unless otherwise specified by EOHHS during design sessions. Inputs will include the following:		
FR.1.	CNOM expenditure data including the following CNOM data as well as any additional CNOMs identified by EOHHS during the design sessions: • Community Health Centers	☐
FR.2.	• Adaptive Telephone Equipment	☐
FR.3.	• Transportation (RIDE)	☐
FR.4.	• DD Day & Supported Employment	☐
FR.5.	• Residential Diversion CBH	☐
FR.6.	• Residential Diversion CW	☐
FR.7.	• Women's Cancer Screening	☐
FR.8.	• Substance Abuse Non-IMD Residential	☐
FR.9.	• Methadone	☐
FR.10.	• Substance Abuse Outpatient	☐
FR.11.	• Reunification Support (DCYF)	☐

ID	EOHHS Requirement	Bidder Acknowledgment
FR.12.	Residential Diversion Voluntary	☐
FR.13.	Additional FACN transactions (payment transactions that are not claims- or client-specific)	☐
FR.14.	Additional claims data	☐
FR.15.	DCYF member data as specified in Section 2.2 to establish financial claiming hierarchy for accurate FMAP reporting	☐
Processing		
FR.16.	Accept, edit and process transactions to produce accurate federal reports	☐
Outputs		
The FA will develop or modify the following standard reports to support accurate federal reporting with appropriate crosswalks to State RIFANS codes:		
FR.17.	Incorporate all program expenditures to automatically calculate the following federally required reports, including, but not limited to: CMS 64	☐
FR.18.	CMS 21	☐
FR.19.	CMS 21b	☐
FR.20.	CMS 37	☐
FR.21.	Create automated standard reports to support federal claiming for the Global Waiver program	☐
FR.22.	Automate currently manually compiled expenditures for management of FMAP and assignment of FMAP rate to service expenditures and recoveries for services processed by the MMIS for EOHHS and other agencies	☐

ID	EOHHS Requirement	Bidder Acknowledgment
FR.23.	Create standard reports defined by the State to compare program expenses to budgeted expenses for the State and federal fiscal year-to-date, prior State and federal fiscal year, and projected through the remainder of the State and federal fiscal year	☐
Interfaces		
FR.24.	Enhance the MMIS interface with the State's accounting systems, RIFANS, to support automation of federal reports	☐
FR.25.	Support an interface between the MMIS and EOHHS Data Warehouse to support automation of federal reports	☐
Fiscal Agent Responsibilities		
FR.26.	Produce federal reports according to federally mandated timelines	☐

6.7.4. Detailed Requirements – Program Reporting

The FA will be responsible for producing standard and ad hoc reports to support program reporting.

The requirements are organized as:

- Inputs
- Processing
- Outputs
- Interfaces
- FA Responsibilities

Bidder acknowledges and accepts responsibility for the following requirements as indicated by checking the box in the column “Bidder Acknowledgment.”

Functional requirements for enhancements are presented in table format below. Complete checklists are included in Appendix O.2 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 32: Requirements for Program Reporting

ID	EOHHS Requirement	Bidder Acknowledgment
Inputs		
PR.1.	The FA will process inputs as necessary to meet the following program reporting requirements. It is anticipated that all program reports will be generated from the EOHHS Data Warehouse except for operational reports that require MMIS data or as otherwise specified by EOHHS during design sessions.	☐
Processing		
PR.2.	Real-time access to case management data	☐
PR.3.	Flexibility to handle numerous global or episodic reimbursement methodologies for a single provider	☐
PR.4.	Flexibility to handle numerous pay-for-performance options	☐
PR.5.	Ability to differentiate FMAP based on EOHHS-specified criteria	☐
PR.6.	Develop and produce standard reports to support the analysis of EOHHS and other agency medical programs, including, but not limited to, fee for service, CNOM and Global Waiver programs	☐
PR.7.	Develop standard reports to measure progress against EOHHS and other agency goals, initiatives, and policy changes, including, but not limited to, policy initiatives, budget initiatives, Affordable Care Act requirements and grant opportunities	☐
PR.8.	Automate reports to support caseload reporting and other legislative and program management requirements	☐
PR.9.	Automate reports to support accurate forecasting of program costs	☐
PR.10.	Automate reports to support evaluation of cost-containment and quality improvement initiatives	☐
PR.11.	Automate reports to support identification of high-cost cases to better focus utilization review and case management programs	☐

ID	EOHHS Requirement	Bidder Acknowledgment
Outputs The FA will generate the following standard reports to support program reporting from the EOHHS Data Warehouse. Reports will be produced from the MMIS only if data is not available in the EOHHS Data Warehouse (for example, operational data). Reports will support EOHHS and other agencies processing claims through the MMIS.		
PR.12.	Reports currently used to support monthly Quality of Care reviews	☐
PR.13.	'What If' reports and scenarios on member populations and provider groups	☐
PR.14.	Reports currently run out of the Rlte Share database to analyze the cost effectiveness of the program	☐
PR.15.	Reports on HEDIS or HEDIS-like measures	☐
PR.16.	Reports currently used to monitor plan performance and calculate outcomes measures as part of performance goal programs	☐
PR.17.	Reports currently produced for the EOHHS monthly financial and program indicators meeting	☐
PR.18.	Reports measuring against adherence to agencies' goals, objectives, and program policy	☐
Interfaces		
PR.19.	Implement an interface and functionality to support Health Information Exchange reporting	☐
Fiscal Agent Responsibilities		
PR.20.	Produce program reports according to State-mandated timelines	☐

6.7.5. Detailed Requirements – Financial Reporting

The FA will enhance MMIS financial reporting by streamlining and enhancing the interface with RI-FANS and the MMIS crosswalk between RIFANS and the MMIS. The FA will modify current reporting to automate certain functions currently done manually.

The requirements are organized as:

- Inputs
- Processing
- Outputs
- Interfaces
- FA Responsibilities

Bidder acknowledges and accepts responsibility for the following requirements as indicated by checking the box in the column “Bidder Acknowledgment.”

Functional requirements for enhancements are presented in table format below. Complete checklists are included in Appendix O.2 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 33: Requirements for Financial Reporting

ID	EOHHS Requirement	Bidder Acknowledgment
Inputs		
FIN.1.	Accept DCYF member data stored in RICHIST to support accurate assignment of funding category and FMAP according to a hierarchy established by EOHHS and DCYF	☐
Processing		
FIN.2.	Review, update and enhance the crosswalk between the MMIS and RIFANS budget categories as directed by EOHHS	☐
FIN.3.	Balance (reconcile) expenditures between RIFANS and the MMIS	☐
FIN.4.	Automate assignment of FMAP to service expenditures and recoveries to the extent specified by EOHHS	☐
FIN.5.	Implement or enhance an automated interface between RIFANS and the MMIS	☐
FIN.6.	Allow for automated updates to Medicaid Budget Forecasting including, but not limited to the following functionality: Updating an Incurred But Not Reported Model (IBNR)	☐
FIN.7.	Re-project spending at any point throughout the year	☐
FIN.8.	Automate rate updates in MMIS	☐
Outputs		
FIN.9.	Standard financial management reports and/or a dashboard on a daily, weekly, monthly, quarterly, and annualized basis	☐
FIN.10.	Standard MMIS operations management reports and/or a dashboard on a daily, weekly, monthly, quarterly, and annualized basis	☐
FIN.11.	Reports currently used to support rate setting	☐

ID	EOHHS Requirement	Bidder Acknowledgment
FIN.12.	Standard reports used to formulate the budget	☐
FIN.13.	Reports currently manually compiled for management of FMAP and assignment of an FMAP rate to service expenditures and recoveries	☐
FIN.14.	Reports showing program expenses compared to budget State fiscal year to date, last State fiscal year and projected expenses through the end of the current State fiscal year	☐
Interfaces		
FIN.15.	Enhance the interface with the State's accounting system, RIFANS, to support automation of financial reporting	☐
Fiscal Agent Responsibilities		
FIN.16.	Maintain the crosswalk between the MMIS and RIFANS budget categories, making updates as necessary to support accurate automated reporting or as directed by EOHHS	☐

6.7.6. Detailed Requirements – Security and Privacy

Bidder acknowledges and accepts responsibility for the following requirements as indicated by checking the box in the column “Bidder Acknowledgment.”

Functional requirements for enhancements are presented in table format below. Complete checklists are included in Appendix O.2 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 34: Requirements for Security and Privacy

ID	EOHHS Requirement	Bidder Acknowledgment
SP.1.	Enforce role-based, member-based, program-based and field-based security to enable efficient use of new enhancements and must, at a minimum, include: Protection of data from State users without a need to know as specified by EOHHS at the field, member and program level	☐
SP.2.	Protection of data from providers with access to the Care Management System	☐
SP.3.	Make EOHHS Data Warehouse data accessible to authorized users based EOHHS-specified criteria at the field, member and program level Maintain a secure site for automated exchange of data with providers, contracted agencies and other entities sharing data with the MMIS, Human Resources Data Warehouse, Care Management System or other data sources identified by DH	☐
SP.4.	Use State secured e-mail as directed by EOHHS	☐

6.8. Transition of Current MMIS Functionality

The Bidder's proposed solution must include the transition and maintenance of the current state of MMIS operations. Bidders should use their expertise in MMIS, Data Warehouse and FA Services to ensure that any additional requirements required for the transition and maintenance of the MMIS, Data Warehouse, and FA services beyond those stated by EOHHS are included and considered in all aspects of their proposal.

Current operations are described in the sections that follow.

6.8.1. Current System Documentation

The Bidder's Library contains information on all current system functional and technical requirements.

6.8.2. Medicaid Enterprise Certification Toolkit Checklists

The CMS-required Medicaid Enterprise Certification Toolkit Checklists issued September 28, 2007 are included in the Bidder's Library. The checklists contain a set of business objectives by business area and a set of system review criteria for each objective. State-Specific business objectives are highlighted and uniquely numbered and include "SS" to indicate State-Specific checklist items. State business objectives are directly tied to the functional requirements contained in this RFP. The current Rhode Island MMIS is provisionally approved by CMS for operation of an MMIS and receipt of full FFP. Vendor is responsible to transition operations of the MMIS at current certification status.

The Bidder's proposed solution is required to meet all CMS and State specific checklist requirements. Refer to this RFP at Section 4: Proposal Submissions Requirements, for instructions on how to respond to the checklist requirements.

Bidder acknowledges and accepts responsibility for the following requirements as indicated by checking the box in the column "Bidder Acknowledgment."

Business Objectives for Enhancements are presented in table format below. Complete checklists are included in Appendix O.4 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 35: Business Objectives for Enhancements

ID	CMS Checklist	Bidder Acknowledgment
Beneficiary Management Business Area		
CMS.1.	Beneficiary Management Checklist	☐
Care Management Business Area		
CMS.2.	Managed Care Enrollment Checklist	☐

ID	CMS Checklist	Bidder Acknowledgment
CMS.3.	Managed Care Organization Interfaces Checklist	☐
CMS.4.	Managed Care PIHP and PAHP Checklist	☐
CMS.5.	PCCM and Gatekeeper Managed Care Checklist	☐
CMS.6.	HCBS Waivers Checklist	☐
CMS.7.	Immunization Registry Checklist	☐
CMS.8.	Immunization Registry Owned Checklist	☐
Provider Management Business Area		
CMS.9.	Provider Management Checklist	☐
Operations Management Business Area		
CMS.10.	Reference Data Management Checklist	☐
CMS.11.	Claims Receipt Checklist	☐
CMS.12.	Claims Adjudication Checklist	☐
CMS.13.	Pharmacy Point of Service Checklist	☐
CMS.14.	Third Party Liability Checklist	☐
Program Management Business Area		
CMS.15.	Program Management Reporting Checklist	☐
CMS.16.	Federal Reporting Checklist	☐
CMS.17.	Financial Management Checklist	☐
CMS.18.	Decision Support System/Data Warehouse Checklist	☐
CMS.19.	Security and Privacy Checklist	☐
Program Integrity Management Business Area		

ID	CMS Checklist	Bidder Acknowledgment
CMS.20.	Program Integrity Checklist	☐

6.8.3. RI MITA SS-A

In preparation for this RFP, the State completed a MITA SS-A based upon the CMS MITA Framework version 2.0. The MITA SS-A included an assessment of Rhode Island Medicaid's current business capabilities as measured using the MITA BCM. Current levels of maturity for each MMIS business process within the Medicaid program were documented to establish a baseline capability profile.

Portions of the MITA SS-A have been included in the Bidder's Library. The following table includes a listing of all current RI business processes that include MMIS processing. Bidders are required to acknowledge transition and maintenance of each business process. Refer to this RFP at Section 4: Proposal Submission Requirements, for instructions on filling out response table.

Bidder acknowledges and accepts responsibility for the following requirements as indicated by checking the box in the column "Bidder Acknowledgment."

Current MITA Business Processes are listed in table format below. Complete checklists are included in Appendix O.5 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 36: Current MITA Business Processes

ID	MITA Business Area	RI Business Process	Bidder Acknowledgment
MITA.1.	Care Management	Manage Case	☐
MITA.2.	Member Management	Inquire RI Medicaid Member Eligibility	☐
MITA.3.	Member Management	Determine RI Medicaid Eligibility	☐
MITA.4.	Member Management	Manage BCCTP Member Information	☐
MITA.5.	Member Management	Manage RI Medicaid Applicant and Member Communication	☐
MITA.6.	Member Management	Manage RI Medicaid Member Information	☐
MITA.7.	Member Management	Enroll Managed Care Member	☐
MITA.8.	Member Management	Disenroll RI Medicaid Member	☐
MITA.9.	Member Management	Determine Respite Eligibility	☐
MITA.10.	Member Management	Determine BCCTP Eligibility	☐
MITA.11.	Member Management	Manage RI Medicaid Member Grievance and Appeal	☐
MITA.12.	Operations Management	Edit and Audit RI Medicaid Encounter	☐
MITA.13.	Operations Management	Prepare Capitation Premium Payment	☐

ID	MITA Business Area	RI Business Process	Bidder Acknowledgment
MITA.14.	Operations Management	Prepare RI Medicaid Remittance Advice	☐
MITA.15.	Operations Management	Prepare RI Medicaid Provider and Premium EFT	☐
MITA.16.	Operations Management	Prepare REOMB	☐
MITA.17.	Operations Management	Price RI Medicaid Claim	☐
MITA.18.	Operations Management	Edit and Audit RI Medicaid Claim	☐
MITA.19.	Operations Management	Apply Void and Replace	☐
MITA.20.	Operations Management	Apply RI Medicaid Claim Attachment	☐
MITA.21.	Operations Management	Establish Care Plan	☐
MITA.22.	Operations Management	Inquire RI Medicaid Payment Status	☐
MITA.23.	Operations Management	Authorize RI Medicaid Service	☐
MITA.24.	Operations Management	Calculate Medically Needy Spend-Down Amount	☐
MITA.25.	Operations Management	Authorize Personal Choice Program	☐
MITA.26.	Operations Management	Prepare RIte Care Member Premium Invoice	☐

ID	MITA Business Area	RI Business Process	Bidder Acknowledgment
MITA.27.	Operations Management	Manage RI Medicaid Drug Rebate	☐
MITA.28.	Operations Management	Manage RI Medicaid Estate Recovery	☐
MITA.29.	Operations Management	Manage RI Medicaid Recoupment	☐
MITA.30.	Operations Management	Manage Hospital Cost Settlement	☐
MITA.31.	Operations Management	Manage RI Medicaid TPL Recovery	☐
MITA.32.	Operations Management	Prepare RIte Share Premium Payment	☐
MITA.33.	Program Integrity Management	Identify RI Medicaid Candidate Case	☐
MITA.34.	Program Integrity Management	Manage RI Medicaid Case	☐
MITA.35.	Program Management	Manage Managed Care Rate Setting	☐
MITA.36.	Program Management	Manage 1099s	☐
MITA.37.	Program Management	Manage State Funds	☐
MITA.38.	Program Management	Manage FMAP	☐
MITA.39.	Program Management	Maintain Benefits-Reference Information	☐

ID	MITA Business Area	RI Business Process	Bidder Acknowledgment
MITA.40.	Program Management	Manage RI Medicaid Program Information	☐
MITA.41.	Program Management	Develop and Manage Performance Measures and Reporting	☐
MITA.42.	Program Management	Generate Financial and Program Analysis Report	☐
MITA.43.	Program Management	Develop and Maintain Program Policy	☐
MITA.44.	Program Management	Manage FFP for MMIS	☐
MITA.45.	Program Management	Manage Standard RI Medicaid Rate Setting	☐
MITA.46.	Program Management	Develop and Maintain Benefit Package	☐
MITA.47.	Program Management	Designate Approved Medicaid Service	☐
MITA.48.	Program Management	Designate Approved Drug Formulary	☐
MITA.49.	Program Management	Formulate Budget	☐
MITA.50.	Provider Management	Disenroll RI Medicaid Provider	☐
MITA.51.	Provider Management	Enroll RI Medicaid Provider	☐
MITA.52.	Provider Management	Inquire RI Medicaid Provider Information	☐

ID	MITA Business Area	RI Business Process	Bidder Acknowledgment
MITA.53.	Provider Management	Manage RI Medicaid Provider Information	☐
MITA.54.	Provider Management	Manage RI Medicaid Provider Grievance and Appeal	☐
MITA.55.	Provider Management	Manage RI Provider Communications	☐
MITA.56.	State Specific	Perform Provider Enrollment Certification	☐

7. Technical Requirements

The Technical Requirements section describes two enhancements with which EOHHS intends to add to its IT infrastructure and improve its technical capabilities with the award of this contract. These two items are separated from the enhancement of Functional Requirements because they are related to implementing a new technological capability, not a new business capability. This section includes for the following:

- An enterprise-scale hardware and networking infrastructure which is referred to as the Web Foundation;
- An ESB for providing a service-oriented software infrastructure for integrating applications and systems; and
- Transition of current MMIS technical capabilities.

7.1. Web Foundation

EOHHS is procuring the new Web Foundation in order to support current and future enhancements to the MMIS and other systems. Each of the existing environments, such as the MMIS environment and the EOHHS Data Warehouse (CHOICES MMIS) environment were created for the specific needs of the system being implemented. The systems are deployed on various hardware platforms, operating systems, and database management systems. With the creation of the Web Foundation, EOHHS wishes to create a single cloud-based network and software infrastructure for implementing new Web-based applications. Web-based communications and application hosting are essential to meeting the data-sharing and application integration goals specified in the federal guidance and the State technology plan. It is the intent of EOHHS to purchase the Web Foundation as a service from the FA, hosted in the FA's data center.

7.1.1. Web Foundation Narrative

The scope of the Web foundation is limited to the hardware and software required to host enterprise scale Web applications, and facilitate data-sharing and system integration across system and organizational boundaries. The Web foundation will need to support services across the three traditional architectural tiers (i.e., presentation, application, and data) in the form of a Web farm, middle-tier applications servers, and database servers. Each tier has both hardware and software requirements. For example, the presentation tier includes both the hardware and networking capabilities to support a Web server farm, and the software required to operate that farm. The immediate utilization of this foundation will be in five areas:

- The hosting of the Care Management System described in this RFP;
- The hosting of the Case Tracking application described in this RFP (for program integrity, estate recovery and casualty);

- The hosting of the Provider Call Center application described in this RFP;
- The hosting of the EOHHS Data Warehouse (CHOICES MMIS) by the FA after transition; and
- The hosting of the ESB described in Section 7.2 of this RFP.

(Note: The Bidder may propose a single solution for the Care Management System and Case Tracking application if feasible.)

In its response, the Bidder should specify its proposal for creating a Web Foundation with adequate resources to support these applications in multiple environments. The FA may propose using the same technology and resources used in applications such as the MMIS and the EOHHS Data Warehouse, but must ensure that the proposed solution has the necessary system resources to meet the demands of these additional systems. One of the purposes of both the Web Foundation and the ESB is to create a single hardware and software infrastructure for developing and deploying future systems.

To be an enterprise scale environment capable of hosting mission critical applications certain requirements must be met which are detailed in the table below. The Web Foundation should consist of physical or virtual server clusters that are configured to share processing responsibilities. The server clusters must have features such as load balancing and failover, to provide high-availability and improved performance. Load balancing can be implemented using either hardware or software. Server clusters must be scalable to efficiently handle a growing amount of work or to be readily enlarged to meet increased demand. Server clusters in Web Foundation must possess all of these characteristics.

The Web Foundation must have a presentation tier Web farm that is used to accept and process requests over the Internet or an intranet, using standard Web communication protocols. These requests may be from Web-based user interfaces (Web pages), or Web-based services. In order to process Web-based requests, a Web server (e.g., Microsoft IIS, IBM WebSphere, or Apache Web Server) must be included as part of the Web farm proposal.

The Web Foundation must provide an application tier server cluster that manages middleware software servers, such as an ESB, Business Rules Engine (BRE), and/or business service components.

The Web Foundation must include a data tier server cluster that manages the interaction between application tier services and Database Management System (DBMS) or other data stores. In addition to managing business application data and the data warehouse, the data tier server clusters must manage application tier server data. For example, an ESB or BRE often requires a DBMS in order to manage its data.

7.1.2. Web Foundation Requirements

The Web Foundation requirements are listed in the table below. While these are the only requirements, each Bidder's proposal must specify the exact hardware,

networking equipment and software it is proposing for the Web Foundation. For example, the requirements do not specify the use of physical or virtual servers, but the Bidder should include that information in its proposal. In addition, the Bidder should specify the proposed configuration of the hardware and software and the scalability potential of the proposed solution. The costs for the Web Foundation should be detailed in accordance with specification outlined in the cost proposal section of this RFP.

Web Foundation Requirements are presented in table format below. Complete checklists are included in Appendix O.3 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 37: Web Foundation Requirements

ID	EOHHS Requirement	Bidder Acknowledgment
WF.1	The Web Foundation must have a development environment.	☐
WF.2	The Web Foundation must have a testing environment.	☐
WF.3	The Web Foundation must have a User Acceptance testing environment.	☐
WF.4	The Web Foundation must have a production environment	☐
WF.5	The Web Foundation must create a server cluster in each architectural tier.	☐
WF.6	The Web Foundation server clusters must have high availability.	☐
WF.7	The Web Foundation server clusters must be load balanced.	☐
WF.8	The Web Foundation must include a presentation tier server cluster.	☐
WF.9	The Web Foundation must include an application tier server cluster.	☐
WF.10	The Web Foundation must include a data tier server cluster.	☐
WF.11	The Web Foundation servers must be able to scale vertically, up to the physical limitations of the selected hardware and software.	☐
WF.12	The Web Foundation server clusters must be able to scale horizontally up to the physical limitations of the selected hardware and software.	☐
WF.13	The Web Foundation will provide a Web server (software) in the presentation tier.	☐

7.2. Enterprise Service Bus

An ESB is a message-oriented middleware infrastructure that increases software interoperability, portability, and flexibility by allowing systems to communicate over multiple heterogeneous platforms. It can reduce the complexity of developing applications that span multiple platforms, operating systems and network protocols by using software industry standards for communication, service interface definitions and messaging formats.

An ESB is the descendant of the message brokers and Enterprise Application Integration products of the past. In the simplest terms, an ESB carries and delivers messages between systems and applications. One of the main advantages of using an ESB is that it provides a single place for point-to-point connections between systems, applications or services. This approach simplifies internal and external system integration and interoperability, and is a core component in the MITA Technical Architecture.

As part of a long-term strategy, EOHHS will lay the foundation for a SOA through the acquisition and implementation of an ESB. Initially, the ESB is to be used to integrate the Legacy MMIS with the Care Management System being acquired in this contract. The implementation of an ESB is EOHHS's first step towards achieving its vision for a service-oriented systems model in which various systems produce and consume information services across system and organizational boundaries.

7.2.1. ESB Narrative

In general, an ESB can be configured to accept messages from applications on multiple platforms using various communication protocols. In this instance, the Legacy MMIS may exist in one physical environment while the ESB and new Care Management System are implemented on the new Web Foundation environment described in Section 7.1 of this RFP. Integration between the Legacy MMIS and the Care Management System should occur through the ESB. However, the ESB may require an integration gateway to facilitate communication across the different hardware platforms. Therefore, the proposal for the ESB should include details about both the ESB itself and an integration gateway, if one is required.

Typically, an ESB can be configured to accept and respond to messages using various communication protocols. One of the more common uses for an ESB in Medicaid organizations is to process HIPAA transactions. Therefore, an ESB for Medicaid usually accepts and sends messages using the EDI standards. Support for certain communication protocols is listed in the requirements; however Bidders' proposals should identify all the protocols supported in the proposed solution.

After receiving a message, an ESB will route the message based on some set of criteria. Often this is done through a subscription and routing mechanism. Services will subscribe to messages that are of a particular type, the ESB will

manage the subscriptions and route incoming messages to the services which subscribe to messages of that type. The ESB may then wait for a response from the service (synchronous processing) or not (asynchronous processing). Bidders' proposals should describe the message processing capabilities of the ESB.

The ESB, like most enterprise systems, may have components that physically reside on different hardware tiers. For example, an ESB will have an administration console that allows ESB Administrators to set up the communication locations through which the ESB receives and sends messages. Those user interfaces may be deployed on servers in the presentation tier of the Web Foundation. The ESB message processing engine that receives messages and delivers them to their appropriate destination will most likely reside in the application tier. Finally, an ESB must store messages and data required to operate the application in the data tier, most likely in a DBMS. Bidders' proposals should describe the software architecture of the ESB and describe how it will be deployed on the new Web Foundation.

There are numerous ESB or ESB capable products available in the software market. Some products are designed exclusively as ESB's and others have the ability to provide ESB capabilities, as well as other features. Each product is different and will be evaluated against the requirements listed below and the specific capabilities of the product as described in the proposal.

7.2.2. ESB Requirements

The ESB requirements are listed in the table below. While these are the only requirements, proposals should describe all the capabilities of the proposed solution. For example, the proposed solution may support additional communication protocols that are not listed in the requirements, and those protocols should be identified in the proposal. The costs for the ESB should be detailed in accordance with specifications outlined in the Cost Proposal Submission Requirements section of this RFP.

ESB Requirements are presented in table format below. Complete checklists are included in Appendix O.3 to this RFP. Bidders must complete the checklists and include them in the proposal.

Table 38: ESB Requirements

ID	EOHHS Requirement	Bidder Acknowledgment
ESB.1	The ESB will have the ability to accept request messages using HTTP and HTTPS.	☐
ESB.2	The ESB will have the ability to accept request messages using Web Service protocols.	☐
ESB.3	The ESB will have the ability to accept request messages based on a location in the file system.	☐

ID	EOHHS Requirement	Bidder Acknowledgment
ESB.4	The ESB will have the ability to accept request messages using EDI.	☐
ESB.5	The ESB will include an integration gateway to the MMIS if necessary.	☐
ESB.6	The ESB will have the ability to respond to request messages synchronously.	☐
ESB.7	The ESB will have the ability to respond to request messages asynchronously.	☐
ESB.8	The ESB will have the ability to validate messages that are received according to a defined XML schema.	☐
ESB.9	The ESB will have the ability to transform messages based on a transformation mapping.	☐
ESB.10	The ESB will have the ability to route messages based on message content and routing subscriptions.	☐
ESB.11	The ESB will have the ability to respond to request messages using HTTP.	☐
ESB.12	The ESB will have the ability to respond to request messages using Web Service protocols.	☐
ESB.13	The ESB will have the ability to respond to request messages using a location in the file system.	☐
ESB.14	The ESB will have the ability to respond to request messages using EDI.	☐
ESB.15	The ESB will have the ability to maintain a history of all messages processed.	☐
ESB.16	The ESB will have the ability to ensure that each message is delivered to all the appropriate subscribers.	☐
ESB.17	The ESB will have the ability to verify that each message is only delivered to the appropriate subscribers.	☐
ESB.18	The ESB will ensure that messages that cannot be delivered will be sent to a location which allows the content of the message to be viewed by an administrator.	☐
ESB.19	The ESB processing engine must be deployed on the application tier of the Web Foundation.	☐
ESB.20	The integration gateway must be deployed on the application tier of the Web Foundation.	☐
ESB.21	The ESB user interfaces may be deployed on the presentation tier of the Web Foundation.	☐
ESB.22	The ESB data services must be deployed on the data tier of the Web Foundation.	☐

8. Evaluation and Selection

This section includes the approach to proposal evaluation, the evaluation process, selection of the Contractor, and the Contract approval process.

8.1. Evaluation Approach

Rhode Island will conduct a comprehensive, fair and impartial evaluation of proposals in response to this procurement. The State will select the Successful Bidder through a formal evaluation process, established prior to the opening and evaluation of proposals, which will remain fixed throughout the procurement cycle.

Consideration will be given to capabilities or advantages which are clearly described in each proposal, confirmed by oral presentations or interviews, and verified by information from reference sources contacted by the State. The State reserves the right to contact individuals, entities, or organizations who have had recent contracts or relationships with the firm or staff proposed for this effort, whether or not they are identified as references, to verify that the Bidder has successfully performed their contractual obligations in other similar efforts.

The evaluation will be conducted in the following four phases:

- Phase I - Selection of Responsive Proposals
- Phase II - Evaluation of Technical Proposals
- Phase III - Evaluation of Cost Proposals
- Phase IV - Selection of the Successful Bidder

There are a total of one thousand (1,000) points that can be awarded for each proposal. Seven hundred (700) points may be awarded for the Technical Proposal and three hundred (300) for the Cost Proposal.

The estimated procurement schedule is shown in the following table:

Table 39: Estimated Procurement Schedule, Post Submittal

Activity	Estimated Dates
RFP Issued	November 21, 2011
Mandatory Bidder's Conference	December 7, 2011 (1:30 PM ET)
Notice of Intent to Submit a Proposal Due	December 12, 2011 (1:00 PM ET)
Closing Date for Written Questions	December 19, 2011 (3:00 PM ET)
Responses Posted to Bidder's Conference Questions	January 2, 2012
Addendum to RFP Posted (if necessary)	January 9, 2012
Closing Date for Receipt of MMIS Proposals/Bid Opening	February 4, 2012 (3:00 PM ET)

Oral Presentations	February 2012 (TBD)
Bidder Selection; Notification of Intent to Award MMIS FA Contract	March 22, 2012

8.2. Evaluation Committee

The State will select an Evaluation Committee to evaluate Bidder responses and make a final recommendation for selection to the State. The Evaluation Committee will be responsible for evaluating the Technical and Cost Proposals, including the final scoring of all proposals, resolving compliance issues, and preparing the final report which recommends a Bidder for selection.

Members of the Evaluation Committee may represent any of the following departments: DHS, DCYF, DoA, Divisions of Purchasing and Division of Information Technology, and EOHHS. In order to bring the appropriate expertise to the selection process, the Evaluation Committee may be comprised of program, procurement, and information systems staff. The State reserves the right to designate other appropriate experts to assist in the process or to alter the composition of the Evaluation Committee, as deemed necessary.

8.3. Evaluation Process

This section describes the activities and responsibilities for each phase of the evaluation process.

- Phase I - Selection of Responsive Proposals
- Phase II - Evaluation of Technical Proposals
- Phase III - Evaluation of Cost Proposals
- Phase IV - Selection of the Successful Bidder

8.3.1. Phase I – Selection of Responsive Proposals

This section describes identification of responsive proposals and evaluation of mandatory requirements.

The purpose of this phase of the evaluation is to determine if each Technical Proposal responds to the mandatory terms and conditions of the RFP. A responsive proposal shall comply with all instructions listed in this RFP at Section 2: Procurement Rules and Section 4: Proposal Submission Requirements. If a proposal does not meet all the Mandatory Technical Proposal Submission Requirements, as listed in Appendix M to this RFP, it may be eliminated from further consideration.

The State reserves the right to reject any or all of the proposals received, or cancel this RFP, in the best interest of the State. The State also reserves the right to waive minor irregularities in proposals, providing that such action is

deemed to be in the best interest of the State. Where the State may waive minor irregularities, as determined by the Evaluation Committee, such waiver shall in no way modify RFP requirements or excuse the Bidder from full compliance with RFP specifications and other Contract requirements if the Bidder is awarded the Contract.

All proposals submitted will become the property of the State and will be considered a matter of public record after Contract negotiations are complete.

Receipt of Bidder proposals by the specified date and time will be verified by the DoA's Division of Purchasing Procurement Officer. Proposals received in a timely and appropriate manner will be opened and reviewed by the Evaluation Committee for evaluation of detailed compliance with the requirements of this RFP. Technical Proposals will first be reviewed to determine if they comply with the Mandatory Technical Proposal Submission Requirements detailed in this RFP at Section 2: Procurement Rules, Section 4: Proposal Submission Requirements, and Appendix M.

The Evaluation Committee will review each Technical Proposal to identify areas where the proposals may be non-responsive to requirements, are otherwise defective, or in which additional clarification is required in order that the State may fully understand the ramifications of an action proposed by a Bidder.

As a result of this review, the Evaluation Committee will prepare an agenda of items to be discussed with each Bidder based on any deficiencies and/or clarifications noted in any or all Bidders' proposals. The agenda may also include a discussion of the Bidder's proposed staffing plans and requested Contract changes, as appropriate. The State will use the agenda for the topics covered in the Oral Presentations.

8.3.2. Phase II – Evaluation of Technical Proposals

This section describes evaluation of Technical Proposals, including scoring criteria. It also includes provisions for Oral Presentations and processes for clarification of proposals.

Only those proposals found to be responsive under Phase I shall be evaluated in Phase II.

During the course of the Phase II evaluation, the State will request Oral Presentations of Bidders or the opportunity to interview proposed key personnel. Reference checks may also be made. The State however reserves the right to make an award without further clarification of the proposals received.

The purpose of the Oral Presentations is to provide additional information on material presented in the proposals or to demonstrate the efficacy of the proposed solution. The State may request demonstrations of certain functionality in order to help clarify the Bidder's proposal.

The State will specify the key personnel identified in the Bidder's proposal to participate in Oral Presentations. The questions to be asked of the personnel will

include background and relevant experience, together with situational business related questions. The State will set the agendas for Oral Presentations.

The evaluation of Technical Proposals will involve the point scoring of each proposal that is declared responsive in Phase I. A maximum of 700 points will be available for each Technical Proposal.

Technical Proposals will be evaluated on criteria established and documented prior to receipt of proposals. Point distributions by category for Technical Proposals are shown in the following table.

Table 40: Point Distributions for Technical Proposals

Proposal Category	Points
Total Technical Proposal	700
Bidder Qualifications and Experience	100
Approach to Project Management	50
Approach to Project Staffing	100
Approach to Transition Activities	Pass/Fail
Approach to Enhancement Activities	150
Approach to Turnover Activities	Pass/Fail
Approach to Certification Activities	Pass/Fail
Approach to Maintenance and Operations	200
Oral Presentations	100
Total Cost Proposal	300

The State will evaluate the Bidder's response to each of the specific proposal submission requirements which are identified in this RFP. High-level descriptions of each domain and what will be evaluated are described in this section. These descriptions are provided as guidance to Bidders in preparing proposals and are not all-inclusive of evaluation criteria or factors to be considered by the Evaluation Committee in assigning scores for each area.

Bidder Qualifications and Experience. In this section (valued at 100 of the possible 700 Technical Proposal points), the Bidder's experience, corporate resources, and corporate qualifications will be evaluated. Areas to be considered include Bidder experience in all activities described in this RFP at Section 5: Statement of Work and that meet the requirements of this RFP at Section 6: Functional Requirements and Section 7: Technical Requirements. Client references and information received through other sources may also be evaluated.

Approach to Project Management. In this section (valued at 50 of the possible 700 Technical Proposal points), the Bidder's approach to project management and coordination with the project management office will be evaluated.

Evaluators will consider the approach, work plan and staffing to perform the activities identified in this RFP at Section 5: Statement of Work and meets the requirements in this RFP at Section 6: Functional Requirements and Section 7: Technical Requirements.

Approach to Transition Activities. In this section (valued as Pass/Fail), the Bidder's approach to Transition activities will be evaluated. Evaluators will consider the approach, work plan and staffing to perform the activities identified in this RFP at Section 5: Statement of Work around Transition Activities.

Approach to Project Staffing. In this section (valued at 100 of the possible 700 Technical Proposal points), the Bidder's key personnel and staffing plan for all phases will be evaluated. Resumes of key personnel will be evaluated. Three (3) individual client references will be required and evaluated. Evaluators will consider experience of key staff with implementation, enhancements and maintenance and operations of an MMIS as required this RFP at Section 5: Statement of Work and to meet the requirements of this RFP at Section 6: Functional Requirements and Section 7: Technical Requirements.

Approach to Enhancements Activities. In this section (valued at 150 of the possible 700 Technical Proposal points), the Bidder's approach to implementing the enhancements listed in this RFP will be evaluated. The Evaluation Committee will evaluate the overall approach to performing the activities identified in this RFP at Section 5.4: Enhancement Activities and to meet the requirements identified in this RFP at Section 6: Functional Requirements and Section 7: Technical Requirements. Evaluators will consider proposal responses of the RFP considering all functional and technical enhancements and will evaluate the work plan and staffing, schedule, methodologies, testing, quality assurance and other design, development and implementation considerations for implementing those enhancements.

Approach to Turnover Activities. In this section (valued as Pass/Fail), the Bidder's approach to Turnover activities will be evaluated. Evaluators will consider the approach, work plan and staffing to perform the activities identified in that RFP at Section 5: Statement of Work around Turnover Activities.

Approach to Certification Activities. In this section (valued as Pass/Fail), the Bidder's approach to Certification activities will be evaluated. Evaluators will consider the approach, work plan and staffing to perform the activities identified in this RFP at Section 5: Statement of Work around Certification Activities.

Approach to MMIS Maintenance and Operations. In this section (valued at 200 of the possible 700 Technical Proposal points), the Bidder's approach to ongoing maintenance and operations of the MMIS and related functions as defined in this RFP at Section 5: Statement of Work will be evaluated. The Evaluation Committee will evaluate the overall approach to performing the activities identified in this RFP at Section 5: Statement of Work and to meet the requirements of this RFP at Section 6: Functional Requirements and Section 7: Technical Requirements. Evaluation will consider all maintenance and operations for the Medical Assistance Program, Global Waiver programs and

related medical and social programs required in this RFP. Evaluators will consider Bidder responses to the checklists for meeting all federal and State requirements for ongoing operations.

Oral Presentations. In this section (valued at 100 of the possible 700 points), the Evaluation Committee will consider the information presented in Oral Presentations and the degree to which the presentations support the Bidder's Technical Proposal, the experience and knowledge of key staff on the scope of work and activities to be performed and the technical and functional requirements, and how well the presentation clarified the State's questions regarding the Bidder's proposal.

8.3.3. Phase III – Evaluation of Cost Proposals

Eligible Cost Proposals will be evaluated after the completion of Phase II of the evaluation. Only those Cost Proposals for which corresponding Technical Proposals have passed the requirements in Phases I and II will be reviewed and scored. The Evaluation Committee will examine each eligible Cost Proposal to determine if it is complete, in compliance with the Mandatory Cost Proposal Submission Requirements in this RFP at Section 2: Procurement Rules, Section 4: Proposal Submission Requirements, and Appendix M, accurate in its calculations, and consistent with its Technical Proposal. Any proposal that does not meet these criteria will be considered to be an unresponsive Cost Proposal and may be rejected.

Three hundred (300) points will be awarded to the responsive Cost Proposal with the lowest total price as stated as the Total Evaluated Price for Contract on Schedule A of the Cost Proposal.

Cost scores will then be normalized to one another, based on the lowest cost proposal evaluated. The lowest cost proposal receives a total of 300 points. The normalization formula follows:

$$\text{Bidder's Cost Score} = (\text{Lowest Cost Proposal Price divided by the Bidder's Cost Proposal Price}) \times 300$$

In all cases, the Cost Proposal Price will be the Total Evaluated Price for Contract on Schedule A of the Cost Proposal.

The required Cost Proposal schedules and supporting cost information will be checked for mathematical accuracy.

8.3.4. Phase IV – Selection of Successful Bidder

The Evaluation Committee will combine the scores of each Bidder's Technical Proposal and Cost Proposal for each proposal that met the mandatory requirements for Phases I, II, and III. Final selection will be on the basis of best value, and in the best interest of the State.

The Department of Administration's, Division of Purchasing Procurement Officer will notify the Apparent Successful Bidder and all other Bidders in writing of the selection decision

8.4. Contract Approvals

The State will require the selected Bidder to participate in contract negotiations regarding the terms and conditions of the contract. Upon resolution of the final negotiations, the State will prepare a final contract. If for any reason the State and the apparent Successful Bidder are unable to reach agreement of the terms and conditions of a contract, the State may then proceed to negotiate a contract with the Bidder with the next highest rated proposal. The State may cancel negotiations entirely at any time at the exclusive discretion of the State.

In order to secure maximum FFP and State matching funds, the contract award is contingent upon both federal and State of Rhode Island reviews and approvals. Every effort will be made by the State, both before and after selection, to facilitate rapid approval. The State will obtain all required State and federal approvals prior to start of work by the FA.

9. Contract Terms and Conditions

By signing and submitting its proposal, the Bidder agrees to be bound by all the terms contained in this RFP. This includes the:

- State's General Conditions of Purchase (Section 9.1 of this RFP); and
- Information Technology (IT) Terms and Conditions (Section 9.2 of this RFP).

Contract terms and conditions are defined in the following sections.

9.1. State's General Conditions of Purchase

The State's General Conditions of Purchase contain the specific contract terms, stipulations, and affirmations to be used for the Contract awarded to the FA for this RFP. The State's General Conditions of Purchase may be found at the Website www.purchasing.ri.gov and are listed in Appendix A to this RFP.

9.2. IT Terms and Conditions

This section includes Rhode Island IT Terms and Conditions. All IT Terms and Conditions apply to the Contract resulting from this procurement.

9.2.1. General Provisions

The terms and conditions of this Contract are intended by the parties as a final expression of their Contract with respect to the subject matter hereof and may not be contradicted by evidence of any prior contemporaneous Contract unless such Contract is signed by both parties. In the absence of such an Contract, this Contract shall constitute the complete and exclusive statement of the terms and conditions, and no extrinsic evidence whatsoever may be introduced in any judicial proceeding, which may involve the Contract. This Contract may not be modified, except by mutual consent executed in writing by both parties as described in Section 9.2.63 of this RFP.

In the event of a conflict in language among any of the components of the Contract, the RFP shall govern. The State reserves the right to clarify any contractual relationship in writing, and such clarification will govern in case of conflict with the requirements of this RFP.

9.2.2. Definitions

The following terms shall be given the meaning shown, unless context requires otherwise or a unique meaning is otherwise specified:

- **"Acceptance Tests"** means those tests performed during the Performance Testing Period which are intended to determine compliance of Equipment and Software with the specifications and all other Attachments incorporated herein by reference and to determine the reliability of the Equipment.

- **"Application Program"** means a computer program that is intended to be executed for the purpose of performing useful work for the user of the information being processed.
- **"Attachment"** means a mechanical, electrical, or electronic interconnection to the FA-supplied Machine or System of Equipment, manufactured by other than the original Equipment manufacturer, that is not connected by the FA.
- **"Business entity"** means any individual, business, partnership, joint venture, corporation, S-corporation, limited liability corporation, limited liability partnership, sole proprietorship, joint stock company, consortium, or other private legal entity recognized by statute.
- **"Buyer"** means the State's authorized contracting official.
- **"Commercial Software"** means Software developed or regularly used that: (i) has been sold, leased, or licensed to the general public; (ii) has been offered for sale, lease, or license to the general public; (iii) has not been offered, sold, leased, or licensed to the public but will be available for commercial sale, lease, or license in time to satisfy the delivery requirements of this Contract; or (iv) satisfies a criterion expressed in (i), (ii), or (iii) above and would require only minor modifications to meet the requirements of this Contract.
- **"Contract"** means this Contract or agreement (including any purchase order), by whatever name known or in whatever format used.
- **"Custom Software"** means Software that does not meet the definition of Commercial Software.
- **"Contractor"** means the Business Entity with whom the State enters into this Contract. Contractor shall be synonymous with "Fiscal Agent/FA," "supplier," "vendor" or other similar term, including its or their subcontractors and agents.
- **"Data Processing Subsystem"** means a complement of Contractor-furnished individual Machines, including the necessary controlling elements (or the functional equivalent) and Operating Software, if any, which are acquired to operate as an integrated group, and which are interconnected entirely by Contractor-supplied power and/or signal cables; e.g., direct access controller and drives, a cluster of terminals with their controller, etc.
- **"Data Processing System (System)"** means the total complement of Contractor-furnished Machines, including one or more central processors (or instruction processors) and Operating Software, which are acquired to operate as an integrated group. This term includes without limitation all tangible and/or intangible assets used to perform the services to be rendered by Contractor under this Contract.

- **"Deliverables"** means Goods, Software, Information Technology, telecommunications technology, documentation, software code, tangible outcomes, and other items (e.g. reports) to be delivered pursuant to this Contract, including any such items furnished incident to the provision of services. This term includes without limitation all tangible and/or intangible assets used to perform the services to be rendered by Contractor under this Contract.
- **"Designated CPU(s)"** means for each product, if applicable, the central processing unit of the computers or the server unit, including any associated peripheral units. If no specific "Designated CPU(s)" are specified on the Contract, the term shall mean any and all CPUs located at the site specified therein.
- **"Documentation"** means nonproprietary manuals and other printed materials necessary or useful to the State in its use or maintenance of the Equipment or Software provided hereunder. Manuals and other printed materials customized for the State hereunder constitute Documentation only to the extent that such materials are described in or required by the SOW.
- **"Equipment"** is an all-inclusive term which refers either to individual Machines or to a complete Data Processing System or subsystem, including its Hardware and Operating Software (if any).
- **"Equipment Failure"** is a malfunction in the Equipment, excluding all external factors, which prevents the accomplishment of the Equipment's intended function(s). If microcode or Operating Software residing in the Equipment is necessary for the proper operation of the Equipment, a failure of such microcode or Operating Software which prevents the accomplishment of the Equipment's intended functions shall be deemed to be an Equipment Failure.
- **"Facility Readiness Date"** means the date specified in the SOW by which the State must have the site prepared and available for Equipment delivery and installation.
- **"Goods"** means all types of tangible personal property, including but not limited to materials, supplies, and Equipment (including computer and telecommunications Equipment).
- **"Hardware"** usually refers to computer Equipment and is contrasted with Software. See also Equipment.
- **"Installation Date"** means the date specified in the SOW by which the Contractor must have the ordered Equipment ready (certified) for use by the State.
- **"Information Technology"** includes, but is not limited to, all electronic technology systems and services, automated information handling, System design and analysis, conversion of data, computer programming,

information storage and retrieval, telecommunications which include voice, video, and data communications, requisite System controls, simulation, electronic commerce, and all related interactions between people and Machines.

- **"Machine"** means an individual unit of a Data Processing System or subsystem, separately identified by a type and/or model number, comprised of but not limited to mechanical, electro-mechanical, and electronic parts, microcode, and special features installed thereon and including any necessary Software, e.g., central processing unit, memory module, tape unit, card reader, etc.
- **"Machine Alteration"** means any change to a Contractor -- supplied Machine which is not made by the Contractor, and which results in the Machine deviating from its physical, mechanical, electrical, or electronic (including microcode) design, whether or not additional devices or parts are employed in making such change.
- **"Maintenance Diagnostic Routines"** means the diagnostic programs customarily used by the Contractor to test Equipment for proper functioning and reliability.
- **"Manufacturing Materials"** means parts, tools, dies, jigs, fixtures, plans, drawings, and information produced or acquired, or rights acquired, specifically to fulfill obligations set forth herein.
- **"Mean Time Between Failure (MTBF)"** means the average expected or observed time between consecutive failures in a System or component.
- **"Mean Time to Repair (MTTR)"** means the average expected or observed time required to repair a System or component and return it to normal operation.
- **"Operating Software"** means those routines, whether or not identified as Program Products, that reside in the Equipment and are required for the Equipment to perform its intended function(s), and which interface the operator, other Contractor-supplied programs, and user programs to the Equipment.
- **"Operational Use Time"** means, for performance measurement purposes, that time during which Equipment is in actual operation by the State. For maintenance Operational Use Time purposes, that time during which Equipment is in actual operation and is not synonymous with power on time.
- **"Performance Testing Period"** means a period of time during which the State, by appropriate tests and production runs, evaluates the performance of newly installed Equipment and Software prior to its acceptance by the State.
- **"Period of Maintenance Coverage"** means the period of time, as selected by the State, during which maintenance services are provided by

the Contractor for a fixed monthly charge, as opposed to an hourly charge for services rendered. The Period of Maintenance Coverage consists of the Principal Period of Maintenance and any additional hours of coverage per day, and/or increased coverage for weekends and holidays.

- **"Preventive Maintenance"** means that maintenance, performed on a scheduled basis by the Contractor, which is designed to keep the Equipment in proper operating condition.
- **"Principal Period of Maintenance"** means any nine consecutive hours per day (usually between the hours of 7:00 AM and 6:00 PM) as selected by the State, including an official meal period not to exceed one hour, Monday through Friday, excluding holidays observed at the installation.
- **"Programming Aids"** means Contractor-supplied programs and routines executable on the Contractor's Equipment which assists a programmer in the development of applications including language processors, sorts, communications modules, data base management systems, and utility routines (e.g., tape-to-disk routines, disk-to-print routines, etc.).
- **"Program Product"** means programs, routines, subroutines, and related items which are proprietary to the Contractor and which are licensed to the State for its use, usually on the basis of separately stated charges and appropriate contractual provisions.
- **"Remedial Maintenance"** means that maintenance performed by the Contractor which results from Equipment (including Operating Software) failure, and which is performed as required (i.e., on an unscheduled basis).
- **"Site License"** means for each product, the term "Site License" shall mean the license established upon acquisition of the applicable number of copies of such product and payment of the applicable license fees as set forth in the SOW.
- **"Software"** means an all-inclusive term which refers to any computer programs, routines, or subroutines supplied by the Contractor, including Operating Software, Programming Aids, Application Programs, and Program Products.
- **"Software Failure"** means a malfunction in the Contractor-supplied Software, other than Operating Software, which prevents the accomplishment of work, even though the Equipment (including its Operating Software) may still be capable of operating properly. For Operating Software failure, see definition of Equipment Failure.
- **"State"** means the government of the State of Rhode Island, its employees and authorized representatives, including without limitation any department, agency, or other unit of the government of the State of Rhode Island

- **"System"** means the complete collection of Hardware, Software and services as described in this Contract, integrated and functioning together, and performing in accordance with this Contract.
- **"U.S. Intellectual Property Rights"** means intellectual property rights enforceable in the United States of America, including without limitation rights in trade secrets, copyrights, and U.S. patents.

9.2.3. **Complete Integration**

This Contract, including any documents incorporated herein by express reference, is intended to be a complete integration, and there are no prior or contemporaneous different or additional agreements pertaining to the subject matter of the Contract.

9.2.4. **Severability**

The Contractor and the State agree that if any provision of this Contract is found to be illegal or unenforceable, such term or provision shall be deemed stricken and the remainder of the Contract shall remain in full force and effect. Either party having knowledge of such term or provision shall promptly inform the other of the presumed non-applicability of such provision.

9.2.5. **Independent Contractor**

Contractor and the agents and employees of Contractor, in the performance of this Contract, shall act in an independent capacity and not as officers, employees, or agents of the State.

The Contractor as an independent contractor is solely liable for the acts and omissions of its employees and agents.

The Contractor shall be exclusively responsible for payment of employees and contractors for all wages and salaries, taxes, withholding payments, penalties, fees, fringe benefits, professional liability insurance premiums, contributions to insurance, and pension or other deferred compensation plans, including but not limited to, Workers' Compensation and Social Security obligations, and licensing fees, etc., and the filing of all necessary documents, forms and returns pertinent to all of the foregoing.

The Contractor shall hold the State harmless, and shall provide the State with a defense against any and all claims including, but not limited to, the foregoing payments, withholdings, contributions, taxes, social security taxes, and employer income tax returns.

The Contractor shall not assign, convey, transfer, or delegate any of its responsibilities and obligations under this Contract to any person, corporation, partnership, association or entity without expressed written consent of the State.

9.2.6. Applicable Law

This Contract shall be governed by and shall be interpreted in accordance with the laws of the State of Rhode Island; venue of any action brought with regard to this Contract shall be in Providence County, Providence, Rhode Island.

The Contractor shall comply with applicable federal, State and local laws and regulations.

9.2.7. Compliance with Statutes and Regulations

Contractor warrants and certifies that in the performance of this Contract, it will comply with all applicable statutes, rules, regulations and orders of the United States and the State of Rhode Island and agrees to indemnify the State against any loss, cost, damage or liability by reason of the Contractor's violation of this provision.

9.2.8. Contractor's Power and Authority

The Contractor warrants that it has full power and authority to grant the rights herein granted and will hold the State harmless from and against any loss, cost, liability, and expense (including reasonable attorney fees) arising out of any breach of this warranty. Further, Contractor avers that it will not enter into any arrangement with any third party, which might abridge any rights of the State under this Contract.

9.2.9. Assignment

This Contract shall not be assignable by the Contractor in whole or in part without the written consent of the State. For the purpose of this paragraph, the State will not unreasonably prohibit Contractor from freely assigning its right to payment, provided that Contractor remains responsible for its obligations hereunder.

The Contractor shall not sell, transfer, assign, or otherwise dispose of the Contract or any portion thereof or of any right, title, or interest therein without written consent of the State. Any such purported assignment or transfer shall be void. If approved, any assignee shall be subject to all terms and conditions of this Contract. No approval by the State of any assignment may be deemed to obligate the State beyond the provisions of this Contract. This provision includes reassignment of the Contract due to change in ownership of the Contractor. The State shall at all times be entitled to assign or transfer its rights, duties, and/or obligations under this Contract to another governmental agency in the State of Rhode Island upon giving prior written notice to the Contractor.

9.2.10. Waiver of Rights

Any action or inaction by the State or the failure of the State on any occasion to enforce any right or provision of the Contract, shall not be construed to be a waiver by the State of its rights hereunder and shall not prevent the State from enforcing such provision or right on any future occasion. The rights and

remedies of the State herein are cumulative and are in addition to any other rights or remedies that the State may have at law or in equity.

9.2.11. Order of Precedence

In the event of any inconsistency between the articles, attachments, specifications, or provisions which constitute this Contract, the following order of precedence shall apply:

- Contract form (i.e., Purchase Order, Agreement, etc., and any amendments thereto).
- These General Provisions – Information Technology (IT) Terms & Conditions.
- State's General Conditions of Purchase.
- RFP
- The SOW, including any specifications incorporated by reference herein, shall only be used to describe the Contractor's work for the State and shall not be allowed to change the order hereof unless approved by the Legal Department, Department of Administration, and the Chief Purchasing Officer.
- Contractor's offer (the selected Bidder's response to this RFP).
- All other attachments incorporated into the Contract by reference.

9.2.12. Packing and Shipment

All Goods are to be packed in suitable containers for protection in shipment and storage, and in accordance with applicable specifications. Each container of a multiple container shipment shall be identified to:

- Show the number of the container and the total number of containers in the shipment; and
- The number of the container in which the packing sheet has been enclosed.

All shipments by Contractor or its subcontractors must include packing sheets identifying: the State's Contract number; item number; quantity and unit of measure; part number and description of the Goods shipped; and appropriate evidence of inspection, if required. Goods for different Contracts shall be listed on separate packing sheets.

Shipments must be made as specified in this Contract, as it may be amended, or otherwise directed in writing by the State's Division of Purchases.

9.2.13. Transportation Costs and Other Fees or Expenses

No charge for delivery, drayage, express, parcel post, packing, cartage, insurance, license fees, permits, cost of bonds, or for any other purpose will be paid by the State unless expressly included and itemized in the Contract.

- Contractor must strictly follow Contract requirements regarding Free on Board (F.O.B.), freight terms and routing instructions. The State may permit use of an alternate carrier at no additional cost to the State with advance written authorization of the Buyer.
- If "prepay and add" is selected, supporting freight bills are required when over \$50, unless an exact freight charge is approved by the Transportation Management Unit within the State's Division of Purchases.
- On "F.O.B. Shipping Point" transactions, should any shipments under the Contract be received by the State in a damaged condition and any related freight loss and damage claims filed against the carrier or carriers be wholly or partially declined by the carrier or carriers with the inference that damage was the result of the act of the shipper such as inadequate packaging or loading or some inherent defect in the Equipment and/or material, Contractor, on request of the State, shall at Contractor's own expense assist the State in establishing carrier liability by supplying evidence that the Equipment and/or material was properly constructed, manufactured, packaged, and secured to withstand normal transportation conditions.
- The State will not reimburse the Contractor for any Travel or Entertainment expenses.

9.2.14. Delivery

Contractor shall strictly adhere to the delivery and completion schedules specified in this Contract. Time, if stated as a number of days, shall mean calendar days unless otherwise specified. The quantities specified herein are the only quantities required. If Contractor delivers in excess of the quantities specified herein, the State shall not be required to make any payment for the excess deliverables, and may return them to Contractor at Contractor's expense or utilize any other rights available to the State at law or in equity.

9.2.15. Substitutions

Substitution of deliverables may not be tendered without advance written consent of the Buyer. Contractor shall not use any specification in lieu of those contained in the Contract without written consent of the Buyer.

9.2.16. Inspection, Acceptance and Rejections

The Contractor shall perform its activities and produce the required deliverables by the due dates presented in the Contractor(s) work plan for each deliverable

defined in the final Contract for Transition, Enhancement, Operation, and Maintenance of the Medicaid Management Information System Provisions for deliverable submission, review and acceptance, rejection, or requests for modifications shall proceed as established in this RFP. The following provisions apply:

- Payment terms may be based on work accepted – per deliverable minus retainage
- The final balance will be paid upon final acceptance of all Contract deliverables

Unless otherwise specified in the SOW:

- Contractor and its subcontractors will provide and maintain a quality assurance system acceptable to the State covering deliverables and services under this Contract and will tender to the State only those deliverables that have been inspected and found to conform to this Contract's requirements. Contractor will keep records evidencing inspections and their result, and will make these records available to the State during Contract performance. Contractor shall permit the State to review procedures, practices, processes, and related documents to determine the acceptability of Contractor's quality assurance System or other similar business practices related to performance of the Contract.
- By submitting a deliverable, the Contractor represents that, to the best of its knowledge, it has performed the associated activities in a manner, which will, in concert with other activities, meet the objectives stated or referred to in the Contract. By approving a deliverable, the State represents only that it has reviewed the deliverable and detected no errors or omissions of sufficient gravity to defeat or substantially threaten the attainment of those objectives and to warrant the withholding or denial of payment for the work completed. The State's approval of a deliverable does not discharge any of the Contractor's contractual obligations with respect to that deliverable, or to the quality, comprehensiveness, functionality, effectiveness, or certification of the Rhode Island MMIS as a whole, or the Contractor's meeting of the requirements of the MMIS RFP. The parties agree that Contract requirements shall be modified only through work authorizations and/or an amendment to the Contract.
- All deliverables may be subject to inspection and test by the State or its authorized representatives in order to monitor and evaluate performance, compliance, and/or quality assurance under this Contract on behalf of the State at all times.
- Contractor and its subcontractors shall provide all reasonable facilities for the safety and convenience of inspectors at no additional cost to the State. Contractor shall furnish to inspectors all information and data as may be reasonably required to perform their inspection.

- All deliverables may be subject to final inspection, test and acceptance by the State at destination, notwithstanding any payment or inspection at source.
- All software installed for any system enhancement will not be considered operational until it has passed an acceptance test for functionality and performance according to the process defined in this RFP at Section 5: Statement of Work.

9.2.17. Payment and Withholds

The State will limit payment for the MMIS project costs (transition, enhancement, maintenance and operations, and turnover) to the amount proposed by the Contractor and agreed to by the State. The Contractor will be expected to adhere to the amounts and rates agreed to in the resulting Contract.

The total maximum amount payable under the Contract for FA services and the operation of the systems which comprise the MMIS shall not exceed the total amount of the Contract, excluding pass-through items and Special Projects.

9.2.18. MMIS Takeover and Transition Activities

The State will authorize no payments for takeover and transition activities as described in this RFP at Section 5: Statement of Work.

9.2.19. Maintenance and Operations Payments

The State will authorize monthly payments (in arrears) of Maintenance and Operations services upon approved invoices submitted by the Contractor. Maintenance and Operations payments will be based on provisions for SLAs as described in Section 9.2.20 of this RFP.

Monthly payments will include the following:

- **MMIS Systems Costs.** The State shall pay the Contractor a base annual price for maintenance and operation of the MMIS and related systems. MMIS Systems Costs will include MMIS Operations Costs, Claims Processing Support Services, Transaction Processing Costs, and Other Costs. The MMIS Systems Costs shall be invoiced on a monthly basis in equal monthly payments. The MMIS Systems Costs will be as proposed in the Pricing Schedules in the Contractor's Cost Proposal and finalized in the Contract resulting from this procurement.
- **MMIS System Modification Services.** The State shall pay the Contractor for modification of the system to reflect customer-required changes as prioritized and approved by EOHHS. The hourly rate for hours delivered for each year shall be as proposed as the Modification Costs in the Pricing Schedules in the Contractor's Cost Proposal and finalized in the Contract resulting from this procurement. Modification hours will be charged as separate professional services outside the base

services. A total of two thousand (2,000) modification hours are included in the annual base services rate as defined in (a) above.

- Postage will be billed to the State as a pass-through expense. Expenses include costs for ID card mailing, PO Box fees, UPS cost or other carrier costs and actual metered amounts incurred by the contractor on a monthly basis.

9.2.20. Service Level Agreements

The State will monitor the Contractor's performance during Maintenance and Operations using a performance reporting system to be implemented by the Contractor. Each SLA presented in this RFP at Section 5: Statement of Work establishes the performance level expected by the State in a particular area. KPIs are identified within each SLA and are to be measured and reported each month by the Contractor. The SLAs are:

1. System Availability
2. System Performance
3. Database Updates
4. Operational Problem Management
5. Customer Service Support
6. Claims Adjudication
7. Claims Payment
8. Reporting
9. Drug Rebate

Performance Monitoring. The KPIs used to define the service levels are an adjunct to the performance standards established in Section 5 – Statement of Work. The State has identified the KPIs to be key indicators of the Contractor's operational performance. Failure to achieve a KPI may, at the discretion of State, result in financial retainage.

Monthly Reporting. The Contractor is expected to monitor performance against the State-specified KPIs in this document, and is to develop operations reports to demonstrate compliance with applicable KPIs. The Contractor is to submit a monthly Performance Report Card on all KPIs, regarding the prior month's performance, no later than the 10th of the month, with out-of-bounds metrics visually highlighted in the report. The Contractor may include additional information regarding SLA compliance in its report. The Contractor is to make available to the State upon request all reports or data used in the determination of SLA compliance and calculation of KPIs. The automated reports are to be flexible and adaptable to changes in the performance measurements through a rules-based engine, or component of a rules-based engine, in the MMIS.

Corrective Action. When a KPI is not met, the Contractor is expected to provide the State with a written detailed Corrective Action Report which describes: the missed KPI, a full description of the issue, the cause of the problem, risks related to the issue, the resolution, including any failed solution implemented prior to resolution, and the proposed corrective action going forward to avoid missing the KPI in the future. Upon receipt of the report, the State may request a meeting to further discuss issues. The Contractor is to implement proposed corrective action only upon approval of State.

Periodic Reviews. Prior to commencement of Maintenance and Operations, the State and Contractor will review all KPIs to determine if revisions are needed. After the Start of Operations, similar reviews will be held annually, upon the implementation of a change that impacts existing KPIs, or at the request of the State.

Right to Retainage. The State and the Contractor agree that failure by the Contractor to perform in accordance with established KPIs results in a loss to the State. If the Contractor fails to meet the KPIs identified in the SLAs listed in this RFP at Section 5: Statement of Work, the State may retain a percentage of the billed amount, as identified in each SLA in Appendix J to this RFP and deduct the specified amounts from the fees due to the Contractor for the total of MMIS Systems Costs billed that month.

9.2.21. Payment for Enhancement Activities

The State will pay a single firm fixed price for completion and State approval of all deliverables associated with each enhancement implemented during the Enhancement Activities as described in this RFP at Section 5: Statement of Work. Prices for each enhancement will be based on the Pricing Schedules in the Contractor's Cost Proposal as finalized in the Contract resulting from this procurement.

Ten percent (10%) of the price of each enhancement proposed on the Pricing Schedules in the Contractor's Cost Proposal will be retained until completion and State approval of all enhancements and completion of the Enhancement Activities.

Another ten percent (10%) of the price of each enhancement proposed on the Pricing Schedules in the Contractor's Cost Proposal will be retained until receipt of CMS certification for the enhanced Rhode Island MMIS. If CMS certification is not required for any enhancement, the ten percent will be paid upon State approval of all enhancements and completion of the Enhancement Activities.

9.2.22. Samples

Samples of items may be required by the State for inspection and specification testing and must be furnished free of expense to the State. The samples furnished must be identical in all respects to the products bid and/or specified in the Contract.

Samples, if not destroyed by tests, may, upon request made at the time the sample is furnished, be returned at Contractor's expense.

9.2.23. Warranty

The warranties in this subsection begin upon final acceptance of all deliverables and continue during the term of this Contract. Contractor warrants that: (i) deliverables and services furnished hereunder will substantially conform to the requirements of this Contract (including without limitation all descriptions, specifications, and drawings identified in the SOW); and (ii) the deliverables will be free from material defects in materials and workmanship. Where the parties have agreed to design specifications (such as a business or Detailed Design Document) and incorporated the same or equivalent in the SOW directly or by reference, Contractor will warrant that its deliverables provide all material functionality required thereby. In addition to the other warranties set forth herein, where the Contract calls for delivery of Commercial Software, Contractor warrants that such Software will perform in accordance with its license and accompanying Documentation. The State's approval of designs or specifications furnished by Contractor shall not relieve the Contractor of its obligations under this warranty.

Contractor warrants that deliverables furnished hereunder: (i) will be free, at the time of delivery, of harmful code (e.g., computer viruses, worms, trap doors, time bombs, disabling code, or any similar malicious mechanism designed to interfere with the intended operation of, or cause damage to, computers, data, or Software); and (ii) will not infringe or violate any U.S. Intellectual Property Right. Without limiting the generality of the foregoing, if the State believes that harmful code may be present in any Commercial Software delivered hereunder, Contractor will, upon the State's request, provide a master copy of the Software for comparison and correction.

Unless otherwise specified in the SOW: Contractor does not warrant and will have no responsibility for a claim to the extent that it arises directly and in whole form from (i) a modification made by the State, unless such modification is approved or directed by Contractor, (ii) use of Software in combination with or on products other than as specified, recommended or approved by Contractor, or (iii) misuse by the State.

All warranties, including special warranties specified elsewhere herein, shall inure to the State, its successors, assigns, customer agencies, and governmental users of the deliverables or services.

For any breach of any of the warranties provided in this section, without limiting any other remedies to which the State may be entitled, the State's remedies include, without limitation, the following: (i) re-performance, repair, or replacement of the nonconforming deliverable (including without limitation an infringing deliverable) or service; or (ii) should the State in its sole discretion consent, refund of all amounts paid by the State for the nonconforming deliverable or service and payment to the State of any additional amounts

necessary to equal the State's Cost to Cover. "Cost to Cover" means the cost, properly mitigated, of procuring deliverables or services of equivalent capability, function, and performance.

9.2.24. Safety and Accident Prevention

In performing work under this Contract on State premises, Contractor shall conform to any specific safety requirements contained in the Contract or as required by law or regulation. Contractor shall take any additional precautions as the State may reasonably require for safety and accident prevention purposes. Any violation of such rules and requirements, unless promptly corrected, shall be grounds for termination of this Contract in accordance with the default provisions hereof.

9.2.25. Insurance

Throughout the term of this Contract, the Contractor, and any Subcontractor where required, shall procure and maintain, at its own cost and expense, and provide annually to the State certificates of insurance evidencing the following:

- i. General comprehensive liability insurance policy based on Insurance Services Office (ISO) policy forms or equivalent forms with the following minimum coverage on an occurrence basis with respect to the Services and other operations performed pursuant to this Contract by Contractor and its employees agents, suppliers, agents and invitees:

Bodily Injury and Property Damage	\$1,000,000 each occurrence \$1,000,000 annual aggregate
Products and Completed Operations	\$1,000,000 each occurrence 1,000,000 annual aggregate
Contractual Liability and Property Damage	\$1,000,000 each occurrence \$1,000,000 annual aggregate
Independent Contractors	\$1,000,000 each occurrence \$1,000,000 annual aggregate
Personal and Advertising Injury	\$1,000,000 each occurrence \$1,000,000 annual aggregate

- ii. Vehicle liability insurance using ISO or equivalent forms with the following minimum coverage with respect to the operations by anyone with the permission of the Contractor or subcontractor including coverage for owned, non-owned and hired vehicles and equipment:

Bodily Injury	\$1,000,000 each occurrence
Property Damage	\$1,000,000 each occurrence
Combined Single Limit	\$1,000,000 per occurrence

- iii. A Technology Errors and Omissions Policy or Professional Liability Policy in the amount of at least \$1,000,000 each occurrence and \$1,000,000 annual aggregate arising out of or resulting from the performance of Services under this Contract covering: Errors and Omissions, Product Failure, Security Failure, Professional Liability and Personal Injury. Insured will include any individual who is an agent or independent contractor while acting within the scope of his or her contract with the named insured under the Contract.
- iv. Workers compensation insurance for Contractor and any Subcontractor as required by applicable federal and State law, including employer's liability:

Employers Liability	\$500,000 each accident
Disease limit each employee	\$500,000 each accident
Disease Policy Limit	\$500,000 each accident

- v. Commercial Crime Policy covering all Contractor's officers and employees with a limit of \$1,000,000 for Employee Theft, \$1,000,000 for Computer Fraud and \$1,000,000 Funds Transfer Fraud, all per occurrence and annual aggregate. Contractor shall make State a joint loss payee under the Commercial Crime Policy, for their respective interests, during the term of the Contract.
- vi. Under Contractor's property insurance in the event that information of the State is being stored or worked upon not on State property, or software is being prepared, developed or modified not on State Property, the State requires the Contractor have no less than \$250,000 in Electronic Data Processing Equipment and Extra Expense insurance in order that the software and data belonging to the State if damaged shall be expeditiously restored to its original format and content.
- vii. The State of Rhode Island and EOHHS shall be listed as an additional insured on Contractor's Liability Policies. Contractor shall submit to the State a copy of the policy endorsement evidencing the State and EOHHS as additional insureds.
- viii. Contractor and any Subcontractor agree to a waiver of subrogation.
- ix. Certificates of Insurance, acceptable to State, shall be submitted to State upon execution of this Contract and shall be renewed upon expiration of the policies. Certificates shall indicate that the coverage required is in effect. If the State is damaged by Contractor's failure to maintain insurance, then Contractor shall be responsible for all reasonable costs or damages attributable thereto. All policies shall be issued by companies authorized to write this type of insurance under the laws of the State of Rhode Island. Any and all deductibles, self insurance or self-insured retention contained in any insurance policy shall be assumed by and at the risk of Contractor. Any such deductible, self-insurance or self-insured

retention shall be less than or equal to Ten Thousand and 00/100 (\$10,000.00) Dollars.

- x. Notice of cancellation or alteration of any kind of insurance referenced above will be sent by the issuing company to State within thirty (30) days prior to cancellation. Failure of Contractor to so notify the State shall constitute an event of default under this Contract.
- xi. A provision that Contractor's insurance shall be primary as respect to any insurance, self-insurance ,or self-retention maintained by the State and shall be in excess of the Contractor's insurance and shall not contribute.
- xii. The State will be defended, indemnified, and held harmless (including attorney's fees and costs) to the full extent of any coverage actually secured by Contractor in excess of the minimums set forth herein. The duty to indemnify the State under this Contract shall not be limited by the insurance required in this Contract.
- xiii. The Purchasing Agent reserves the right to consider and accept alternative forms and plans of insurance, to waive any requirement or to require additional or more extensive coverage for any individual requirement.

9.2.26. Termination of Contract

The Contract resulting from this RFP may be terminated by the State as follows:

- For non-appropriation of funds;
- For the convenience of the State;
- For the Contractor's bankruptcy, insolvency, receivership, or liquidation; or
- For default by the Contractor.

At the State's option, termination for any reason listed herein may also be considered termination for convenience.

Termination for Non-Appropriation of Funds

If the term of this Contract extends into fiscal years subsequent to that in which it is approved, such continuation of the Contract is contingent on the appropriation of funds for such purpose by the Legislature. If funds to effect such continued payment are not appropriated, Contractor agrees to take back any affected deliverables furnished under this Contract, terminate any services supplied to the State under this Contract, and relieve the State of any further obligation therefore with no charge or penalty.

Termination for the Convenience of the State

The State may terminate performance of work under this Contract for its convenience in whole or, from time to time, by notice of Termination specifying the extent of termination and the effective date thereof. Termination shall be effective

as of the close of business on the date specified in the notice, which shall be at least 30 days from the date of receipt of the notice by the Contractor.

After receipt of a Notice of Termination, and except as directed by the State, the Contractor shall immediately proceed with the following obligations, as applicable, regardless of any delay in determining or adjusting any amounts due under this clause. The Contractor shall:

- Stop work as specified in the Notice of Termination;
- Place no further subcontracts for materials, services, or facilities, except as necessary to complete the continuing portion of the Contract;
- Terminate all subcontracts to the extent they relate to the work terminated;
- Settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts; and
- Complete each portion of the Turnover Phase after receipt of the Notice of Termination. The Contractor shall proceed immediately with the performance of the above obligations notwithstanding any allowable delay in determining or adjusting the amount of any item of reimbursable price under this clause. The Contractor has an absolute duty to cooperate and help with the orderly transition of the duties to the State or its designated Contractor following termination of the Contract for any reason.

Unless otherwise set forth in the SOW, if the Contractor and the State fail to agree on the amount to be paid because of the termination for convenience, the State will pay the Contractor the following amounts; provided that in no event will total payments exceed the amount payable to the Contractor if the Contract had been fully performed:

- The Contract price for deliverables or services accepted by the State and not previously paid for, adjusted for any savings on freight and other charges; and the total of:
 - o The reasonable costs incurred in the performance of the work terminated, including initial costs and preparatory expenses allocable thereto, but excluding any cost attributable to deliverables or services paid or to be paid; or “a price commensurate with the actual cost of performance for partially completed deliverables;
 - o The reasonable cost of settling and paying termination settlement proposals under terminated subcontracts that are properly chargeable to the terminated portion of the Contract; and
 - o Reasonable storage, transportation, demobilization, unamortized overhead and capital costs, and other costs reasonably incurred by the Contractor in winding down and terminating its work.

The Contractor will use generally accepted accounting principles, or accounting principles otherwise agreed to in writing by the parties, and sound business practices in determining all costs claimed, agreed to, or determined under this clause. In no event will lost profit be allowed.

Termination for Contractor's Bankruptcy

In the event that the Contractor shall cease conducting business in the normal course, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its 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 the protection of the rights of creditors, the State may, at its option, terminate this Contract in whole or in part.

In the event the State elects to terminate the Contract under this provision, it shall do so by sending Notice of Termination to the Contractor by certified mail, return receipt requested, or delivered in person. The date of termination shall be the close of business on the date specified in such notice to the Contractor. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor, the Contractor shall immediately advise the State.

The Contractor shall ensure and shall satisfactorily demonstrate to the State that all tasks related to the subcontract are performed in accordance with the terms of this Contract.

Termination for Default

The State shall provide the Contractor with advance notice of performance conditions which are endangering the Contract's continuation. If after such notice the Contractor fails to remedy the conditions contained in the notice, within the time period contained in the notice, the State shall issue the Contractor Notice of Termination. The State shall be obligated only for services rendered and accepted prior to the date of the Notice of Termination.

The State may, subject to the clause titled "Force Majeure" and to the section below, by written notice of default to the Contractor, terminate this Contract in whole or in part if the Contractor fails to:

- Deliver the deliverables or perform the services to acceptable quality standards as determined by the State within the time specified in the Contract or any amendment thereto;
- Make progress, so that the lack of progress endangers performance of this Contract;
- Perform any of the other provisions of this Contract; and/or
- Breach State policies or procedures.

The State's right to terminate this Contract may be exercised if the failure constitutes a material breach of this Contract and if the Contractor does not cure such failure within the timeframe stated in the State's cure notice, which in no event will be less than fifteen (15) days, unless the SOW calls for a shorter period.

If the State terminates this Contract in whole or in part pursuant to this section, it may acquire, under terms and in the manner the Buyer considers appropriate,

deliverables or services similar to those terminated, and the Contractor will be liable to the State for any excess costs for those deliverables and services, including without limitation costs third party Contractors' charge for Manufacturing Materials. However, the Contractor shall continue the work not terminated.

If the Contract is terminated for default, the State may require the Contractor to transfer title, or in the case of licensed Software, license, and deliver to the State, as directed by the Buyer, any:

- Completed deliverables;
- Partially completed deliverables;
- Subject to provisions of section e) below, Manufacturing Materials related to the terminated portion of this Contract. Nothing in this section d) will be construed to grant the State rights to deliverables that it would not have received had this Contract been fully performed. Upon direction of the Buyer, the Contractor shall also protect and preserve property in its possession in which the State has an interest; and
- Upon direction of the State, the Contractor shall also protect and preserve property in its possession in which the State has an interest.

The rights and remedies of the State under this clause are in addition to any other rights and remedies provided by law, equity, or under this Contract.

9.2.27. Force Majeure

Except for defaults of subcontractors at any tier, the Contractor shall not be liable for any excess costs if the failure to perform the Contract arises from causes beyond the control and without the fault or negligence of the Contractor. Examples of such causes include, but are not limited to:

- Acts of God or of the public enemy;
- AND
- Acts of the federal or State government in either its sovereign or contractual capacity. If the failure to perform is caused by the default of a subcontractor at any tier, and if the cause of the default is beyond the control of both the Contractor and subcontractor, and without the fault or negligence of either, the Contractor shall not be liable for any excess costs for failure to perform, unless the subcontracted deliverables or services were obtainable from other sources in sufficient time for the Contractor to meet the required delivery schedule.

9.2.28. Rights and Remedies of State for Default

In the event any deliverables furnished or services provided by the Contractor in the performance of the Contract should fail to conform to the requirements herein, or to the sample submitted by the Contractor, the State may reject the same, and it shall become the duty of the Contractor to reclaim and remove the

item promptly or to correct the performance of services, without expense to the State, and immediately replace all such rejected items with others conforming to the Contract.

In addition to any other rights and remedies the State may have, the State may require Contractor, at Contractor's expense, to ship deliverables via air freight or expedited routing to avoid or minimize actual or potential delay if the delay is the fault of the Contractor.

In the event of the termination of the Contract, either in whole or in part, by reason of default or breach by the Contractor, any loss or damage sustained by the State in procuring any items which the Contractor agreed to supply shall be borne and paid for by the Contractor.

The State reserves the right to offset the reasonable cost of all damages caused to the State against any outstanding invoices or amounts owed to Contractor or to make a claim against the Contractor therefore.

9.2.29. Recovery

If a default by the Contractor is not so substantial as to require termination, and the default is capable of being cured by the State, the Contractor shall reimburse the State for the reasonable cost of the services necessary to cure the default. In addition, the Contractor must cooperate with these resources in allowing access to the computer facility, documentation, software, utilities, and equipment. The Contractor shall remain liable for all system performance criteria, maintenance of and further enhancements to any applications developed by these resources to the extent that it constitutes the Contractor's work product.

9.2.30. State's Limitation of Liability

The State's liability for damages for any cause whatsoever, and regardless of the form of action, whether in contract or in tort, shall be limited to the Purchase Price. Nothing herein shall be construed to waive or limit the State's sovereign immunity or any other immunity from suit provided by law.

9.2.31. Contractor's Liability for Injury to Persons or Damage to Property

The Contractor shall be liable for damages arising out of injury to the person and/or damage to the property of the State, employees of the State, persons designated by the State for training, or any other person(s) other than agents or employees of the Contractor, designated by the State for any purpose, prior to, during, or subsequent to delivery, installation, acceptance, and use of the deliverables either at the Contractor's site or at the State's place of business, provided that the injury or damage was caused by the fault or negligence of the Contractor.

9.2.32. Indemnification

Contractor agrees to indemnify, defend and save harmless the State, its officers, agents, and employees from any and all third party claims, costs (including without limitation reasonable attorneys' fees), and losses due to the injury or death of any individual, personal injury, or the loss or damage to any real, tangible, or intangible personal property, resulting from the willful misconduct or negligent acts or omissions of Contractor or any of its agents, subcontractors, employees, suppliers, laborers, or any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract or any failure of the Contractor, its officers, employees, or subcontractors to observe State and federal laws, including, but not limited to, labor and wage laws. Such defense and payment will be conditional upon the following:

- The State will notify Contractor of any such claim in writing and tender the defense thereof within a reasonable time.
- Contractor will have sole control of the defense of any action on such claim and all negotiations for its settlement or compromise; provided that: (i) when substantial principles of government or public law are involved, when litigation might create precedent affecting future State operations or liability, or when involvement of the State is otherwise mandated by law, the State may participate in such action at its own expense with respect to attorneys' fees and costs (but not liability); (ii) the State will have the right to approve or disapprove any settlement or compromise, which approval will not unreasonably be withheld or delayed; and (iii) the State will reasonably cooperate in the defense and in any related settlement negotiations.

9.2.33. Invoices

The Contractor will submit invoices to:

Medicaid Director
Executive Office of Health and Human Services
State of Rhode Island
600 New London Avenue
Cranston, RI 02920

Within 30 days of receipt of a correct invoice by the Department, the Department will remit payments for invoices to the Contractor.

The failure to pay an undisputed payment shall entitle the Contractor to the maximum interest allowed under State law on such unpaid amounts beginning on the 31st day after receipt unless the Department has notified the Contractor in writing of its objections to such invoice.

Invoices must also identify any retainage allowed by Contract until the final deliverable is accepted.

Payment will be made only upon approval of acceptable progress or deliverables as documented by the Contractor and accepted by the State. Invoices may not be submitted more than once monthly. State law forbids payment of invoices prior to receipt of services.

Invoices shall be submitted monthly in triplicate and shall include the Contract number, release order number (if applicable), item number, unit price, extended item price, and invoice total amount.

9.2.34. Taxes

Unless otherwise required by law, the State of Rhode Island is exempt from federal excise taxes. The State will only pay for any State or local sales or use taxes on the services rendered or Goods supplied to the State pursuant to this Contract.

The Contractor shall pay any applicable sales, use, or personal property taxes arising out of this Contract and the transactions contemplated thereby. Any other taxes levied upon this Contract, the transaction, the equipment, or services delivered pursuant here to shall be borne by the Contractor. It is clearly understood that the State of Rhode Island is exempt from any taxes regarding performance of the scope of work of this Contract.

9.2.35. Newly Manufactured Goods

All Goods furnished under this Contract shall be newly manufactured Goods; used or reconditioned Goods are prohibited, unless otherwise specified.

9.2.36. Contract Modification

No amendment or variation of the terms of this Contract shall be valid unless made in writing, signed by the parties, and approved as required. No oral understanding or agreement not incorporated in the Contract is binding on any of the parties.

9.2.37. Confidentiality of Data

All financial, statistical, personal, technical, and other data and information relating to the State's operation which are designated confidential by the State and made available to the Contractor in order to carry out this Contract, or which become available to the Contractor in carrying out this Contract, shall be protected by the Contractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the State. The identification of all such confidential data and information, as well as the State's procedural requirements for protection of such data and information from unauthorized use and disclosure, shall be provided by the State in writing to the Contractor. If the methods and procedures employed by the Contractor for the protection of the Contractor's data and information are deemed by the State to be adequate for the protection of the State's confidential information, such methods and procedures may be used, with the written consent

of the State, to carry out the intent of this paragraph. The Contractor shall not be required under the provisions of this paragraph to keep confidential any data or information which is or becomes publicly available through no fault of Contractor, is already rightfully in the Contractor's possession and which is not subject to prior contrary obligations of confidentiality, is independently developed by the Contractor without the use of such confidential data or information outside the scope of this Contract, or is rightfully obtained from third parties and which is not subject to prior contrary obligations of confidentiality. Contractor and its staff may be required to sign a non-disclosure form.

The Contractor shall safeguard such information and shall return or certify destruction of the information upon Contract expiration or termination.

9.2.38. News Releases

Unless otherwise exempted, news releases pertaining to this Contract shall not be made without prior written approval of the State's Medicaid Director.

9.2.39. Documentation

The Contractor agrees to provide to the State, at no charge, a number of all nonproprietary and proprietary manuals and other printed materials, as described within the SOW, and updated versions thereof, which are necessary or useful to the State in its use of the Equipment or Software provided hereunder. Documentation must be sufficient to use, operate, support, and integrate the system, satisfactory to the State.

If the Contractor is unable to perform maintenance or the State desires to perform its own maintenance on Equipment purchased under this Contract, then, upon written notice by the State, the Contractor will provide at Contractor's then current rates and fees adequate and reasonable assistance including relevant Documentation to allow the State to maintain the Equipment based on Contractor's methodology. The Contractor agrees that the State may reproduce such Documentation for its own use in maintaining the Equipment.

If the Contractor is unable to perform maintenance, the Contractor agrees to license any other Contractor that the State may have hired to maintain the Equipment to use the above noted Documentation. The State agrees to include the Contractor's copyright notice of any such Documentation reproduced, in accordance with copyright instructions to be provided by the Contractor.

9.2.40. Rights in Work Product

All work will be "work for hire" with all rights to intellectual property inuring to the State. The Contractor agrees to make no claims to the intellectual property created in connection with this Contract.

The State agrees that all material appropriately marked or identified in writing as proprietary and furnished hereunder are provided for State's exclusive use for the purposes of this Contract only. All such proprietary data shall remain the

property of the Contractor. State agrees to take all reasonable steps to ensure that such proprietary data are not disclosed to others, without prior written consent of the Contractor, subject to the Rhode Island Access to Public Records Act.

The State will ensure, prior to disposing of any media, that any licensed materials contained thereon have been erased or otherwise destroyed.

The State agrees that it will take appropriate action by instruction, agreement, or otherwise with its employees or other persons permitted access to licensed software and other proprietary data to satisfy its obligations under this Contract with respect to use, copying, modification, protection, and security of proprietary software and other proprietary data.

9.2.41. Patent, Copyright and Trade Secret Indemnity

Contractor will indemnify, defend, and save harmless the State, its officers, agents, and employees, from any and all third party claims, costs (including without limitation reasonable attorneys' fees), and losses for infringement or violation of any U.S. Intellectual Property Right by any product or service provided hereunder. With respect to claims arising from computer Hardware or Software manufactured by a third party and sold by Contractor as a reseller, Contractor will pass through to the State such indemnity rights as it receives from such third party ("Third Party Obligation") and will cooperate in enforcing them; provided that if the third party manufacturer fails to honor the Third Party Obligation, Contractor will provide the State with indemnity protection equal to that called for by the Third Party Obligation, but in no event greater than that called for in the first sentence of this Section 36a). The provisions of the preceding sentence apply only to third party computer Hardware or Software sold as a distinct unit and accepted by the State. *Unless* a Third Party Obligation provides otherwise, the defense and payment obligations set forth in this Section will be conditional upon the following:

- The State will notify Contractor of any such claim in writing and tender the defense thereof within a reasonable time.
- Contractor will have sole control of the defense of any action on such claim and all negotiations for its settlement or compromise; provided that (i) when substantial principles of government or public law are involved, when litigation might create precedent affecting future State operations or liability, or when involvement of the State is otherwise mandated by law, the State may participate in such action at its own expense with respect to attorneys' fees and costs (but not liability); (ii) the State will have the right to approve or disapprove any settlement or compromise, which approval will not unreasonably be withheld or delayed; and (iii) the State will reasonably cooperate in the defense and in any related settlement negotiations.

- Contractor may be required to furnish a bond to the State against any and all loss, damage, costs, expenses, claims and liability for patent, copyright, and trade secret infringement.

Should the Deliverables or Software, or the operation thereof, become the subject of a claim or infringement or violation of the U.S. intellectual property right, the state shall permit the Contractor at its option and expense either to procure for the State the right to continue using the Deliverables or Software, or to replace or modify the same so that they become non-infringing with identical functionality. If none of these options can reasonably be taken, or if the use of such Deliverables or Software by the State shall be prevented by injunction, the Contractor agrees to take back such Deliverables or Software and make every reasonable effort to assist the State in procuring substitute Deliverables or Software. If, in the sole opinion of the State, the return of such infringing Deliverables or Software makes the retention of other Deliverables or Software acquired from the Contractor under this contract impractical, the State shall then have the option of terminating such contract, or applicable portions thereof, without penalty or termination charged by the State. Without limiting the State's remedies, the Contractor agrees to take back such deliverables or software and refund any sums the State has paid Contractor. The Contractor shall have no liability to the State under any provision of this clause with respect to any claim of patent, copyright or trade secret infringement which is based upon:

- The combination or utilization of Deliverables furnished hereunder with Equipment or devices not made, recommended, approved, or furnished by the Contractor.
- The operation of Equipment furnished by the Contractor under the control of any Operating Software other than, or in addition to, the current version of Contractor-supplied Operating Software.
- The unauthorized modification by the State of the Equipment furnished hereunder or of the Software.
- The combination or utilization of Software furnished hereunder with non-contractor supplied Software unless such Software is approved or recommended by the Contractor.

Contractor certifies that it has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Contract for the acquisition, operation or maintenance of computer Software in violation of copyright laws and other intellectual property rights. Contractor further certifies and warrants to the State that it has the legal title to any Software or has obtained the right from the legal owners to use and to license to use to the State.

9.2.42. Examination and Audit

The State will perform audits of the actual costs incurred by the Contractor for all Contract activities. The Contractor is required to maintain and apply a cost accounting system having the capability of accumulating all pertinent cost data in sufficient detail to facilitate this analysis.

Contractor agrees that the State, or its designated representative, and federal personnel shall have the right to review and copy any records and supporting Documentation pertaining to performance of this Contract. Contractor agrees to maintain such records for possible audit by State or federal personnel for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated. Contractor agrees to allow the auditor(s) access to such records during reasonable hours and to allow interviews of any employees or others who might reasonably have information related to such records. Further, Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Contract.

All records, including training records, pertaining to the Contract must be readily retrievable within three (3) workdays for review at the request of the State and its authorized representatives.

When an audit is in progress or audit findings are unresolved, records shall be kept for a period of five (5) years or until all issues are finally resolved, whichever is later.

9.2.43. Stop Work

The State may, at any time, by written Stop Work Order to the Contractor, require the Contractor to stop all, or any part, of the work called for by this Contract for a period up to 90 days after the Stop Work Order is delivered to the Contractor, and for any further period to which the parties may agree. The Stop Work Order shall be specifically identified as such and shall indicate it is issued under this clause. Upon receipt of the Stop Work Order, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize the incurrence of costs allocable to the work covered by the Stop Work Order during the period of work stoppage. Within a period of 90 days after a Stop Work Order is delivered to the Contractor, or within any extension of that period to which the parties shall have agreed, the State shall either:

- Cancel the Stop Work Order;
OR
- Terminate the work covered by the Stop Work Order as provided for in the termination of Contract clause of this Contract (Section 9.2.26 of this RFP).

If a Stop Work Order issued under this clause is canceled or the period of the Stop Work Order or any extension thereof expires, the Contractor shall resume work. The State shall make an equitable adjustment in the delivery schedule, the Contract price, or both, and the Contract shall be modified, in writing, accordingly, if:

- The Stop Work Order results in an increase in the time required for, or in the Contractor's cost properly allocable to the performance of any part of this Contract.
- The Contractor asserts its right to an equitable adjustment within 30 days after the end of the period of work stoppage; provided, that if the State

decides the facts justify the action, the State may receive and act upon a proposal submitted at any time before final payment under this Contract.

If a Stop Work Order is not canceled and the work covered by the Stop Work Order is terminated in accordance with the provision entitled Termination for the Convenience of the State (Section 9.2.30 of this RFP), the State shall allow reasonable costs resulting from the Stop Work Order in arriving at the termination settlement.

The State shall not be liable to the Contractor for loss of profits because of a Stop Work Order issued under this clause.

9.2.44. Covenant Against Gratuities

The Contractor warrants that no gratuities (in the form of entertainment, gifts, or otherwise) were offered or given by the Contractor, or any agent or representative of the Contractor, to any officer or employee of the State with a view toward securing the Contract or securing favorable treatment with respect to any determinations concerning the performance of the Contract. For breach or violation of this warranty, the State shall have the right to terminate the Contract, either in whole or in part, and any loss or damage sustained by the State in procuring on the open market any items which Contractor agreed to supply shall be borne and paid for by the Contractor. The rights and remedies of the State provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or in equity.

9.2.45. Four-Digit Date Compliance

The Contractor warrants that it will provide only Four-Digit Date Compliant (as defined below) Deliverables and/or services to the State. "Four Digit Date Compliant" Deliverables and services can accurately process, calculate, compare, and sequence date data, including, without limitation, date data arising out of or relating to leap years and changes in centuries. This warranty and representation is subject to the warranty terms and conditions of this Contract and does not limit the generality of warranty obligations set forth elsewhere herein.

9.2.46. Americans with Disabilities Act

Contractor assures the State that Contractor complies with the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq).

9.2.47. Governance:

Contractor acknowledges that this engagement is through the Office of the State Chief Information Officer (CIO) and the Division of Purchasing.

9.2.48. Additional Information

The State has the right to require the Contractor to provide additional and periodic information at any time to demonstrate the continued financial responsibility of the Contractor.

9.2.49. Named Individuals Only

All work will be performed only by the specific employees named and agreed to, when applicable. The Contractor will not use any other employee, independent contractor, company, or subcontractor without the prior written consent of the Medicaid Director. Any breach of this condition will be cause for default, with the State reserving the right to cancel the Purchase Order. Any waiver of this condition allowing for substitution must be done in writing.

No re-deployment of any key personnel may be made without prior written consent of the State. The Contractor agrees to supply the Key Personnel proposed for the duration proposed, throughout the life of the Contract other than for just cause. Just cause is defined as death, resignation, termination or military recall. Replacement of such personnel if approved shall be with personnel of equal or greater ability and qualifications.

If an individual identified as Key Personnel becomes unavailable, the Contractor, within ten (10) business days of Contractor's receipt of said individual's notice of unavailability, shall provide the State the resume of three (3) proposed replacements and offer the State an opportunity to interview each person and select the most appropriate replacement candidate. If the State is not reasonably satisfied that the proposed replacement meets the job description criteria set forth in the Contract or is not otherwise suitable for the position, it shall so inform the Contractor in writing within three (3) business days after the later of receiving the resumes or completing any interview of the proposed replacements. Such process shall be repeated until a proposed replacement is approved by the State.

9.2.50. Contractor Personnel

The State shall retain the right to reject any of the Contractor's and/or subcontractor's employees whose qualifications or performance, in the judgment of the State, do not meet the standards established by the State as necessary for the performance of the services.

During the course of the Contract, the State reserves the right to require the Contractor to reassign or otherwise remove from the project any of the Contractor's or a subcontractor's employees who are found to be unacceptable by the State. Upon being notified in writing by the State Contract Administrator that a member of the Contractor's personnel is unacceptable, the Contractor shall immediately remove that individual from any assignments on the Contract. In the event that a member of the Contractor's personnel is removed pursuant to this paragraph, the process set out in Section 9.2.49 of this RFP for submission of resumes, interviews, and approval shall apply as if the person removed were

among the Key Personnel and the vacancy had occurred for a reason other than an internal transfer or ordinary course retirement.

9.2.51. Individual Engagements

The State reserves the right to negotiate pricing on individual engagements. Such terms may be different from the stated amount in the Master Blanket or Purchase Order.

9.2.52. Background Checks/ Non Disclosure Form

The State reserves the right, in its absolute discretion, to conduct criminal and civil background checks prior to or during the term of this Contract. Contractor and its staff may be required to sign a non-disclosure form and/or HIPAA Business Associate Agreement.

9.2.53. Drug Tests

The State reserves the right, in its absolute discretion, to conduct drug test(s) on individuals prior to or during the term of this Contract.

9.2.54. Individual Deliverables:

The State reserves the right, in its absolute discretion, to accept or reject individual deliverables, with an obligation to pay only for those deliverables accepted. The State may agree, in its absolute discretion, to pay a prorated amount of the deliverable price based on a percentage completion of the deliverables.

9.2.55. Change in Price of Deliverables

Any change in the price for any deliverable must receive the prior written approval of the Medicaid Director, or his/her designee and the Division of Purchasing.

9.2.56. Changes in Personnel

Contractor may be responsible, for reimbursement to the State, for all costs associated with unplanned turnover including, but not limited to, briefing and training any new consultants hired by the Contractor after the issuance of the Purchase Order.

The cost reimbursement contemplated in this paragraph is not intended to suggest that the Contractor providing services under a purchase order release is guaranteed the opportunity to replace resources due to unplanned turnover, rather replacement of named individuals under a purchase order release is subject to the terms outlined in Section 9.2.49 of this RFP.

9.2.57. Modifications to Terms, Conditions, Policies etc:

The Terms, Conditions, Policies, and Procedures may be changed during the period of this Contract, provided fifteen (15) days prior written notice is provided to the Contractor. Posting on the Information Technology Division's Website shall constitute permissible notice under this section.

The State may permit changes in the scope of services, time of performance or approved budget of the Contractor to be performed hereunder. Such changes, are mutually agreed upon by the State and the Contractor, must be in writing and shall be made a part of this Contract by numerically consecutive amendments excluding "Special Projects." Special Projects are defined as additional services available to the State on a time and materials or per diem basis as negotiated by project or activity. These activities, which are anticipated to be in support of State health care initiatives, may include enhanced professional services, clinical expertise, technical support to eliminate State backlogs, outreach efforts, etc. The parties understand that these may include funding from State-only programs and grants. The change order will specify the scope of the change and the expected completion date. Any change order shall be subject to the same terms and conditions of the Contract unless otherwise specified in the change order and agreed upon by the parties. The parties will negotiate in good faith and in a timely manner all aspects of the proposed change order.

As soon as possible after receipt of a written change request from the State, but in no event more than thirty (30) days thereafter, the Contractor shall determine if there is an impact on price with the change requested and provide the State a written statement to identify any price impact on the Contract or to state that there is no impact. In the event that price will be impacted by the change, the Contractor shall provide a description of the asserted price increase or decrease involved in implementing the requested change.

No change shall be implemented by the Contractor until such time as the Contractor receives an approved written Change Order.

The State may, at any time, by written order delivered to the Contractor at least thirty (30) days prior to the commencement date of such change, make administrative changes within the general scope of the Contract. If any such change causes an increase or decrease in the cost of the performance of any part of the work under the Contract an adjustment commensurate with the costs of performance under this Contract shall be made in the Contract price or delivery schedule or both. Any claim by the Contractor for equitable adjustment under this clause must be asserted in writing to the State within thirty (30) days from the date of receipt by the Contractor of the notification of change. Failure to agree to any adjustment shall be a dispute within the meaning of the Dispute Resolution clause of this Contract. Nothing in this case, however, shall in any manner excuse the Contractor from proceeding diligently with the Contract as changed.

If the parties are unable to reach an agreement within thirty (30) days of the State receipt of the Contractor's cost estimate, the CIO of the Division of Purchasing

shall make a determination of the revised price, and the Contractor shall proceed with the work according to a schedule approved by the State subject to the Contractor's right to appeal the CIO's determination of the price pursuant to the Disputes Section. Nothing in this clause shall in any manner excuse the Contractor from proceeding diligently with the Contract as changed.

The rate of payment for changes or amendments completed per contract year shall be at the rates specified as Modification Costs in Pricing Schedules C.1 through C.5 in the Contractor's Cost Proposal or as negotiated as a Special Project per this section.

At any time during the term of this Contract, the State may increase the quantity of goods or services purchased under this Contract by sending the Contractor a written amendment or modification to that effect which references this Contract and is signed by the CIO of the Division of Purchasing. The purchase price shall be the lower of the unit cost identified in the Contractor's proposal or the Contractor's then-current, published price. The foregoing shall not apply to services provided to the State at no charge. The delivery schedule for any items added by exercise of this option shall be set by mutual agreement.

9.2.58. Periodic Reporting

The State Medicaid Director the right to request that the Contractor will provide a report, to the CIO, his/her designee, summarizing all contracts with the State, for a Department, deliverables completed, hours, and rates billed, and any material issues during that period.

9.2.59. Waiver of Non-Competition and Related Agreements

The Contractor agrees that the State may hire any employee, consultant, or independent contractor of the Contractor after the employee, consultant, or independent contractor has performed services for the State for period of eighteen (18) months (of 100 hours or more / month) or greater without the payment of any referral fee or other compensation to the Contractor.

The Contractor agrees not to enforce any noncompetition or related agreements to which the employee, consultant or independent contractor is a party and waives any and all claims against the State. If the employee, consultant or independent contractor performed services for the State for a period of less than eighteen (18) months then a referral fee or alternate form of compensation will be negotiated in good faith, not to exceed fifteen percent (15%) of the first year State salary of the employee.

9.2.60. Conflict of Interest

The Contractor affirms that its officers or members or employees presently have no interest and shall not acquire any interest, direct or indirect, which would conflict or compromise in any manner or degree with the performance or its services hereunder. The Contractor further covenants that in the performance of the Contract, the Contractor shall periodically inquire of its officers, members and

employees concerning such interests. Any such interests discovered shall be promptly presented in detail to the State.

9.2.61. Certifications Related to Lobbying

The Contractor certifies that no federal appropriated funds have been paid or will be paid, by or on behalf of the company or an employee thereof, to any person for purposes of influencing or attempting to influence an officer or employee of any federal entity, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee or any agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement the Contractor shall complete and submit a disclosure form to report the lobbying.

The Contractor agrees that this language of certification shall be included in the award documents for all sub-awards at all tiers, including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements, and that all sub-recipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this Contract was made and entered into.

9.2.62. Subcontracts/Joint Ventures

The Contractor is solely responsible for all work performed under the Contract and shall assume prime contractor responsibility for all services offered and products to be delivered under the terms of this Contract. The State will consider the Contractor to be the sole point of contact with regard to all contractual matters. The Contractor may, with the prior written consent of the State, enter into written subcontracts for performance of work under this Contract; however, the Contractor is totally responsible for payment of all subcontracts.

9.2.63. Term of Contract & Renewals

This Contract will be effective (date set upon award) for a period of five (5) years, at which time the Contract may, upon mutual consent, be renewed for up to three (3) one (1)-year contract extension years to be executed at the State's discretion. Unless specific provisions are stipulated in the Contract document, the terms, conditions and pricing established are firm for the life of the Contract.

Contracts that contain renewal provisions may be renewed upon the mutual written consent of the State and Contractor. The renewal(s) will be enacted through the Change Order process, as identified in Section 9.2.57 of this RFP.

9.2.64. Cost of Litigation

In the event that the State deems it necessary to take legal action to enforce any provision of the Contract, the Contractor shall bear the cost of such litigation, as assessed by the court, in which the State prevails. The State shall not bear any of the Contractor's cost of litigation for any legal actions initiated by the Contractor against the State regarding the provisions of the Contract. Legal action shall include administrative proceedings.

9.2.65. Attorney Fees

The Contractor agrees to pay reasonable attorney fees incurred by the State in enforcing this Contract or otherwise reasonably related thereto.

9.2.66. Employment of State Employees

The Contractor shall not knowingly engage on a fulltime, part-time, or other basis during the period of the Contract, any professional or technical personnel who are or have been at any time during the period of the Contract in the employ of the State without the written consent of the State. Further, the Contractor shall not knowingly engage in this project, on a fulltime, part-time, or other basis during the period of the Contract, any former employee of the State who has not been separated from the State for at least one (1) year, without the written consent of the State.

The Contractor shall give priority consideration to hiring interested and qualified adversely affected State employees at such times as requested by the State to the extent permitted by this Contract or State law.

9.2.67. Employment Practices

The Contractor agrees to comply with the requirements of Title VI of The Civil Rights Act Of 1964 (42 USC 2000D et seq.); Section 504 of The Rehabilitation Act of 1973, as amended (29 USC 794); Title IX of The Education Amendments of 1972 (20 USC 1681 et seq.); The United States Department of Health And Human Services Regulations found In 45 CFR, Parts 80 and 84; and The United States Department of Education Implementing Regulations (34 CFR, Parts 104 and 106); which prohibit discrimination on the basis of race, color, national origin, handicap, or sex, in acceptance for or provision of services, employment, or treatment in educational or other programs or activities.

The Contractor acknowledges receipt of Addendum V - Notice To Department Of Human Services Service Providers of Their Responsibilities Under Title VI of The Civil Rights Act of 1964 and Addendum VI - Notice To Department of Human Services Service Providers of Their Responsibilities Under Section 504 of The Rehabilitation Act Of 1973 incorporated herein by reference and made part of this Contract.

The Contractor agrees to comply with all other provisions applicable to law, including The Americans with Disabilities Act Of 1990; The Governor's Executive

Order No. 96-14, which prohibits discrimination on the basis of race, sex, age, national origin, sexual orientation, or disability; and The Governor's Executive Order No. 95-11 relating to sexual harassment.

The Contractor also agrees to comply with the requirements of DHS for Safeguarding of Client Information as such requirements are made known to the provider at the time of this Contract changes to any of the requirements contained herein shall constitute a change and be handled in accordance with 9.2.57.

Failure to comply with this item may be the basis for cancellation of this Contract.

9.2.68. Pro-Children Act of 1994 (ACT)

As a condition of contracting with the State of Rhode Island, the Contractor hereby agrees to abide by the attached Appendix F: Certification Regarding Environmental Tobacco Smoke and in accordance has executed Appendix F: Certification Regarding Environmental Tobacco Smoke.

9.2.69. Drug-Free Workplace Policy

The Contractor agrees to comply with the requirements of the Governor's Executive Order No. 89-14 and the federal Anti-Drug Abuse Act of 1988 as a condition of contracting with the State of Rhode Island, the Contractor hereby agrees to abide by the attached Appendix D: The State's Drug-Free Workplace Policy and in accordance therewith has executed Appendix D: Drug-Free Workplace Policy Contractor Certificate of Compliance.

9.2.70. HIPAA Compliance

The Contractor must comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and must comply with any other applicable (current and future) federal and State laws regarding privacy and confidentiality.

The Contractor must ensure that all work supports the HIPAA Security Rules and sign a HIPAA Business Associate Agreement.

9.2.71. State Contract Administration and Management

Prior to the Effective Date of the Contract, the State shall designate a Contract Administrator to administer the Contract for the State. The State Contract Administrator shall be responsible on behalf of the State for all contractual matters. The State Contract Administrator or a designee(s) authorized in writing shall establish and oversee Contract management functions, including ongoing monitoring and enforcement of Contractor compliance with performance standards and overall terms and conditions of the Contract.

9.2.72. Contractor Contract Administration and Management

The Contractor shall designate an Account Manager who shall be assigned to the Contract and shall be deemed to be Key Personnel for all purposes under the

Contract. The Account Manager shall have the authority to enter into any Contract modifications on behalf of the Contractor and otherwise commit the Contractor to any course of action, undertaking, obligation, or responsibility in connection with the Contractor's performance of the Contract and shall be responsible on behalf of the Contractor for all contractual matters.

9.2.73. Cooperation with Other Contractors

The Contractor shall provide all reasonable assistance to, and cooperation with, all other contractors of the State that are providing goods or services to or on behalf of the State relating to the Project or otherwise providing services to the State, including its agents and/or any contractor or contractors as may be engaged by the State to monitor, validate or verify Contractor's performance. The Contractor shall be liable to the State for the actual additional costs incurred due to its failure to cooperate with other contractors of the State. If reasonably requested to facilitate such cooperation, the Contractor and any other contractor of the State shall enter into written contract(s) that reasonably limit(s) their disclosure and use of each other's confidential information in the course of their performance for the State.

9.2.74. Dispute Resolution

In the event of any dispute arising during the term of the Contract concerning performance of the Contract, either party shall serve notice of such dispute on the other party, and the dispute shall be decided by the State's Contract Administrator, who shall reduce his decision to writing and serve a copy on the Contractor. The decision of the State's Contract Administrator shall be final and conclusive. The State's Contract Administrator's decision in the event of any written notice of dispute shall be final subject to the Contractor's right to relief under applicable law.

9.2.75. Damages – Failure to Meet Contract Requirements

The Contractor shall, at all times, comply with all system and operational performance requirements and expectations specified in this RFP, with Part 11 of the State Medicaid Manual, and with all related Action Transmittals (AT) and Information Memoranda (IM), as well as any modifications or changes thereto, and any changes to 42 CFR, 45 CFR, and 95 CFR as they refer to the MMIS and its operations and the use of FA services.

Notwithstanding anything to the contrary in this Contract, the Contractor warrants takeover and transition of operations of the Rhode Island MMIS shall be complete and the MMIS shall be fully operational by December 1, 2012 or the date finalized in the Contract resulting from this procurement. Fully operational is defined as meeting all CMS requirements for the State to claim the maximum allowable FFP from December 1, 2012 (or the date agreed in the final Contract) through the end of the Contract term.

The Contractor further warrants that it shall meet all performance requirements listed below during the term of this Contract. The Contractor shall, at all times, operate the MMIS and its activities in conformity with the policies and procedures of the Rhode Island Medicaid program.

All requirements described in the RFP are subject to monitoring by the State, or its designee.

Failure of the Contractor to meet these performance requirements in a timely and accurate manner could impede the State in meeting its obligation to its citizens and health care providers and increase the cost of meeting those obligations.

The State agrees that the amounts stated for each occurrence of such performance failure define the maximum damages due from the Contract, and that the State shall adjust the amount downward to eliminate any proportion of the damage caused by the Contractor's failure to meet its contractual responsibility.

If the State elects to not exercise a damage clause in a particular instance, this decision shall not be construed as a waiver of the State's right to pursue associated damages for failure to meet that performance requirement in the future.

It is expressly agreed by the State and the Contractor that, in the event of a failure to meet the performance requirements listed in Sections 9.2.76 through 9.2.79 of this RFP, damage shall be sustained by the State and the Contractor shall pay to the State its actual damages according to the following subsections. Written notice of said failure to perform shall be provided to the Contractor within 30 calendar days of the State's discovery of such failure.

9.2.76. System Certification

Title 42 U.S.C. 1996 b (a)(3)(B) provides for fifty percent (50%) and seventy-five percent (75%) FFP for operation of a mechanized claims payment and information retrieval system approved by CMS. Up to ninety- percent (90%) FFP is available for MMIS-related development costs prior approved by CMS in the State's Advance Planning Document and at Contract signing. The Rhode Island MMIS must throughout the Contract period, meet all certification and re-certification requirements established by CMS. The Contractor shall ensure that federal certification approval for the maximum allowable enhanced FFP for the Rhode Island MMIS is obtained retroactively to assumption at the Start of Operations under the Contractor and is maintained throughout the term of the Contract. Should de-certification of the MMIS, or any component part of it, occur prior to Contract termination or the ending date of any subsequent Contract extension, the Contractor shall be liable for any damages resulting from its actions or inactions.

For any violation of this section the Contractor shall be liable for the State and federal dollar difference between the maximum allowable enhanced FFP and the amount actually received by the State, including any losses due to loss of

certification, failure to obtain approval retroactive to day one, or delays in readiness to support certification. All FFP penalty claims assessed by CMS shall be withheld from monies payable to the Contractor until all such damages are satisfied. Damage assessments shall not be made by the State until CMS has completed its certification approval process and notified the State of its decision in writing.

9.2.77. HHS Sanctions

The Contractor must perform all of its functions according to the terms required by the State Medicaid Manual, Part 11.

If at any time during the life of the Transition, Enhancement, Operation, and Maintenance of the Medicaid Management Information System CMS imposes fiscal sanctions against the State as a result of the Contractor's or any subcontractor's action or inaction, the Contractor shall compensate the State the amount of the sanctions.

9.2.78. Operational Start Date

The Contractor shall have the Rhode Island MMIS fully transitioned and operational on December 1, 2012 or date agreed in the final Contract. Fully operational means beginning processing correctly all claim types, claims adjustments, and other financial transactions; maintaining all system files; producing all required reports; and performing all other Contractor responsibilities specified in this RFP for the takeover MMIS by December 1, 2012 (or the date agreed in the final Contract).

Compliance with the December 1, 2012 (or the date agreed in the final Contract) date is critical to the State's mission. If, for any reason, the Contractor does not fully meet the operational start date approved in the detailed work plan and a Contract modification delaying this date or start-up of a portion of the processing requirements has not been approved, then the Contractor shall be liable for all costs incurred by the State to continue current MMIS and Contractor operations. The Contractor shall also forfeit all claims for reimbursement of monthly expenses or operational payments for that month and each month thereafter until the State approves operational readiness. The State recognizes that some functionality may be operational prior to December 1, 2012 (or the date agreed in the final Contract). If this occurs, the functionality may be activated early and the Contractor will not be penalized for putting the functionality into operation if the State approves operational readiness prior to the December 1, 2012 date (or the date agreed in the final Contract).

9.2.79. Compliance with Other Material Contract Provisions

The objective of this standard is to provide the State 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 this RFP at Section 5: Statement of Work. State

staff may identify contract compliance issues resulting from the Contractor's performance of its responsibilities through routine contract monitoring activities. If this occurs, the State will notify the Contractor in writing of the nature of the performance issue. The State 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.

9.2.80. Required Reporting

Within ten (10) business days after the termination of this Contract, the Contractor will submit to EOHHS an annual statistical report utilizing Form DHS-1003, indicating the annual expenditures and outcomes.

Failure to provide acceptable program and fiscal reports within the prescribed time frames may at the State's option result in a delay of monthly payments for operations and maintenance.

9.2.81. Fiscal Assurances

The Contractor agrees to segregate all receipts and disbursements pertaining to this Contract from recipients and disbursements from all other sources, whether by separate accounts or by utilizing a fiscal code system.

The Contractor assures a system of adequate internal control will be implemented to ensure a separation of duties in all cash transactions.

The Contractor assures the existence of an audit trail which includes: cancelled checks, voucher authorization, invoices, receiving reports and time distribution reports.

The Contractor assures a separate subsidiary ledger of equipment and property will be maintained.

The Contractor agrees any unexpended funds from this Contract are to be returned to the Department at the end of the time of performance unless the Department gives written consent for their retention.

The Contractor assures insurance coverage is in effect in the following categories: bonding, vehicles, fire and theft, and liability.

The following federal requirements shall apply as implied:

- OMB Circular A-21 Cost Principles Institutions for Education
- OMB Circular A-87 Cost Principles Applicable to Grants and Contracts with State and Local Governments
- OMB Circular A-102 Uniform Administrative Requirements for Grants-to-Aid to State and Local Governments
- OMB Circular A-110 Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals, and Other Nonprofit Organizations

- OMB Circular A-122 Cost Principles for Nonprofit Organizations

If the Contractor expends federal awards during the Contractor's particular fiscal year of \$300,000 or more, then OMB Circular A-133, Audits of States, Local Governments and Non-Profit Organizations shall also apply.

This Contract may be funded in whole or in part with federal funds so the CFDA reference number is 93.778.

10. Appendices

Appendix A: State's General Conditions of Purchase

The State's General Conditions of Purchase contain the specific contract terms, stipulations, and affirmations to be utilized for the contract awarded to the vendor for this RFP. The State's General Conditions of Purchase may be found at the Website www.purchasing.ri.gov and are listed in this appendix.

1. GENERAL - All purchase orders, contracts, solicitations, delivery orders, and service requests are for specified goods and services, in accordance with express terms and conditions of purchase, as defined herein. For the purposes of this document, the terms "bidder" and "contractor" refer to any individual, firm, corporation, or other entity presenting a proposal indicating a desire to enter into contracts with the State, or with whom a contract is executed by the State's Purchasing Agent, and the term "contractor" shall have the same meaning as "vendor".

2. ENTIRE AGREEMENT - The State's Purchase Order, or other State contract endorsed by the State Office of Purchases, shall constitute the entire and exclusive agreement between the State and any contractor receiving an award. In the event any conflict between the bidder's standard terms of sale, these conditions or more specific provisions contained in the solicitation shall govern. All communication between the State and any contractor pertaining to any award or contract shall be accomplished in writing.

a. Each proposal will be received with the understanding that the acceptance, in writing, by contract or Purchase Order by the Purchasing Agent of the offer to do work or to furnish any or all the materials, equipment, supplies or services described therein shall constitute a contract between the bidder and the State. This shall bind the bidder on his part to furnish and deliver at the prices and in accordance with the conditions of said accepted proposal and detailed specifications and the State on its part to order from such contractor (except in case of emergency) and to pay for at the agreed prices, all materials, equipment, supplies or services specified and delivered. A contract shall be deemed executor only to the extent of funds available for payment of the amounts shown on Purchase Orders issued by the State to the contractors.

b. No alterations or variations of the terms of the contract shall be valid or binding upon the State unless submitted in writing and accepted by the Purchasing Agent. All orders and changes thereof must emanate from the Office of Purchases: no oral agreement or arrangement made by a contractor with an agency or employee will be considered to be binding on the Purchasing Agent, and may be disregarded.

c. Contracts will remain in force for the contract period specified or until all articles or services ordered before date of termination shall have been satisfactorily delivered or rendered and accepted and thereafter until all terms and conditions have been met, unless

1. terminated prior to expiration date by satisfactory delivery against orders of entire quantities, or

2. extended upon written authorization of the Purchasing Agent and accepted by the contractor, to permit ordering of the unordered balances or additional quantities at the contract price and in accordance with the contract terms, or

3. canceled by the State in accordance with other provisions stated herein.

d. It is mutually understood and agreed that the contractor shall not assign, transfer, convey, sublet or otherwise dispose of this contract or his right, title or interest therein, or his power to execute such contract, to any other person, company or corporation, without the previous consent, in writing, of the Purchasing Agent.

e. If, subsequent to the submission of an offer or issuance of a Purchase Order or execution of a contract, the bidder or contractor shall merge with or be acquired by another entity, the contract may be terminated, except as a corporate resolution prepared by the contractor and the new entity ratifying acceptance of the original bid or contract terms, condition, and pricing is submitted to the Office of Purchases, and expressly accepted.

f. The contractor or bidder further warrants by submission of an offer or acceptance of a Purchase Order or other contract that he has no knowledge at the time of such action of any outstanding and delinquent or otherwise unsettled debt owed by him to the State, and agrees that later discovery by the Purchasing Agent that this warranty was given in spite of such knowledge, except where the matter is pending in hearing or from any appeal therefrom, shall form reasonable grounds for termination of the contract.

3. SUBCONTRACTS - No subcontracts or collateral agreements shall be permitted, except with the State's express consent. Upon request, contractors must submit to the Office of Purchases a list of all subcontractors to be employed in the performance of any Purchase Order or other contract arising from this Request.

4. RELATIONSHIP OF PARTIES - The contractor or bidder warrants, by submission of an offer or acceptance of a Purchase Order or other contract, that he is not an employee, agent, or servant of the State, and that he is fully qualified and capable in all material regards to provide the specified goods and services. Nothing herein shall be construed as creating any contractual relationship or obligation between the State and any sub-bidder, subcontractor, supplier, or employee of the contractor or offeror.

5. COSTS OF PREPARATION - All costs associated with the preparation, development, or submission of bids or other offers will be borne by the offeror. The State will not reimburse any offeror for such costs.

6. SPECIFIED QUANTITY REQUIREMENT - Except where expressly specified to the contrary, all solicitations and contracts are predicated on a specified quantity of goods or services, or for a specified level of funding.

a. The State reserves the right to modify the quantity, scope of service, or funding of any contract, with no penalty or charge, by written notice to the contractor, except where alternate terms have been expressly made a part of contract.

b. The State shall not accept quantities in excess of the specified quantity except where the item is normally sold by weight (where sold by weight, the State will not accept

quantities greater than ten per cent [10%] of the specified quantity), or where the Request or Contract provides for awards for other than exact quantities.

c. Purchase Orders or other contracts may be increased in quantity or extended in term without subsequent solicit with the mutual consent of the contractor and the State, where determined by the Purchasing Agent to be in the State's best interest.

7. TERM AND RENEWAL - Where offers have been requested or contracts awarded for terms exceeding periods of twelve (12) months, it is mutually understood and agreed that the State's commitment is limited to a base term not to exceed twelve (12) months, subject to renewal annually at the State's sole option for successive terms as otherwise described, except where expressly specified to the contrary. Purchase Orders appearing to commit to obligations of funding or terms of performance may be executed for administrative convenience, but are otherwise subject to this provision, and in such cases the State's renewal shall be deemed to be automatic, conditional on the continued availability of appropriated funds for the purpose, except as written notice of the State's intent not to renew is served.

8. DELIVERY - Delivery must be made as ordered and in accordance with the proposal. If delivery qualifications do not appear on the bidder's proposal, it will be interpreted to mean that goods are in stock and that shipment will be made within seven (7) calendar days. The decision of the Purchasing Agent, as to reasonable compliance with the delivery terms, shall be final. Burden of proof of delay in receipt of order shall rest with the contractor. No delivery charges shall be added to invoices except when authorized on the Purchase Order.

9. FOREIGN CORPORATIONS - In accordance with Title 7 Chapter 1.1 of the General Laws of Rhode Island, no foreign corporation shall have the right to transact business in this state until it shall have procured a certificate of authority so to do from the Secretary of State.

10. PRICING - All pricing offered or extended to the State is considered to be firm and fixed unless expressly provided for to the contrary. All prices shall be quoted F.O.B. Destination with freight costs included in the unit cost to be paid by the State, except, where the Request or Contract permits, offers reflecting F.O.B. Shipping Point will be considered, and freight costs may then be prepaid and added to the invoice.

11. COLLUSION - Bidder or contractor warrants that he has not, directly or indirectly, entered into any agreement participated in any collusion or otherwise taken any action in restraint of full competitive bidding. In special circumstances, an executed affidavit will be required as a part of the bid.

12. PROHIBITION AGAINST CONTINGENT FEES AND GRATUITIES – Bidder or contractor warrants that he has not paid, and agrees not to pay, any bonus, commission, fee, or gratuity to any employee or official of the State for the purpose of obtaining any contract or award issued by the State. Bidder or contractor further warrants that no commission or other payment has been or will be received from or paid to any third party contingent on the award of any contract by the State, except as shall have been expressly communicated to the State Purchasing Agent in writing prior to acceptance of the contract or award in question. Subsequent discovery by the State of

non-compliance with these provisions shall constitute sufficient cause for immediate termination of all outstanding contracts and suspension or debarment of the bidder(s) or contractor(s) involved.

13. AWARDS - Awards will be made with reasonable promptness and by written notice to the successful bidder (only); bids are considered to be irrevocable for a period of sixty (60) days following the bid opening unless expressly provided for to the contrary in the Request, and may not be withdrawn during this period without the express permission of the Purchasing Agent.

a. Awards shall be made to the bidder(s) whose offer(s) constitutes the lowest responsive price offer (or lowest responsive price offer on an evaluated basis) for the item(s) in question or for the Request as a whole, at the option of the State. The State reserves the right to determine those offers which are responsive to the Request, or which otherwise serve its best interests.

b. The State reserves the right, before making award, to initiate investigations as to whether or not the materials, equipment, supplies, qualifications or facilities offered by the bidder meet the requirements set forth in the proposal and specification, and are ample and sufficient to insure the proper performance of the contract in the event of award. If upon such examination it is found that the conditions of the proposal are not complied with or that articles or equipment proposed to be furnished do not meet the requirements called for, or that the qualifications or facilities are not satisfactory, the State may reject such a bid. It is distinctly understood, however, that nothing in the foregoing shall mean or imply that it is obligatory upon the State to make any examinations before awarding a contract; and it is further understood that if such examination is made, it in no way relieves the contractor from fulfilling all requirements and conditions of the contract.

c. Qualified or conditional offers which impose limitations of the bidder's liability or modify the requirements of the bid, offers for alternate specifications, or which are made subject to different terms and conditions than those specified by the State may, at the option of the State, be

1. Rejected as being non-responsive, or

2. set aside in favor of the State's terms and conditions (with the consent of the bidder), or

3. accepted, where the State Purchasing Agent determines that such acceptance best serves the interests of the State.

Acceptance or rejection of alternate or counter-offers by the State shall not constitute a precedent which shall be considered to be binding on successive solicitations or procurements.

d. Bids submitted in pencil, or which do not bear an original signature, in ink, by an owner or authorized agent thereof, will not be accepted.

e. Bids must be extended in the unit of measure specified in the Request. In the event of any discrepancy between unit prices and their extensions, the unit price will govern.

f. The Purchasing Agent reserves the right to determine the responsibility of any bidder for a particular procurement.

g. The Purchasing Agent reserves the right to reject any and all bids in whole or in part, to waive technical defects, irregularities, and omissions, and to give consideration to past performance of the offerors where, in his judgment the best interests of the State will be served by so doing.

h. The Purchasing Agent reserves the right to make awards by items, group of items or on the total low bid for all the items specified as indicated in the detailed specification, unless the bidder specifically indicates otherwise in his bid.

i. Preference may be given to bids on products raised or manufactured in the State, other things being equal.

j. The impact of discounted payment terms shall not be considered in evaluating responses to any Request.

k. The Purchasing Agent reserves the right to act in the State's best interests regarding awards caused by clerical errors by the Office of Purchases.

14. **SUSPENSION AND DEBARMENT** - The Purchasing Agent may suspend or debar any vendor or potential bidder, for good cause shown:

a. A debarment or suspension against a part of a corporate entity constitutes debarment or suspension of all of its divisions and all other organizational elements, except where the action has been specifically limited in scope and application, and may include all known corporate affiliates of a contractor, when such offense or act occurred in connection with the affiliate's performance of duties for or on behalf of the contractor, or with the knowledge, approval, or acquiescence of the contractor or one or more of its principals or directors (or where the contractor otherwise participated in, knew of, or had reason to know of the acts).

b. The fraudulent, criminal or other serious improper conduct of any officer, director, shareholder, partner, employee, or any other individual associated with a contractor may be imputed to the contractor when the conduct occurred in connection with the individual's performance of duties for or on behalf of the contractor, or with the contractor's knowledge, approval or acquiescence. The contractor's acceptance of benefits derived from the conduct shall be evidence of such knowledge, approval, or acquiescence.

c. A vendor or contractor who knowingly engages as a subcontractor for a contract awarded by the State to a vendor or contractor then under a ruling of suspension or debarment by the State shall be subject to disallowance of cost, annulment or termination of award, issuance of a stop work order, or debarment or suspension, as may be judged to be appropriate by the State Purchasing Agent.

15. **PUBLIC RECORDS** - Contractors and bidders are advised that all documents, correspondence, and other submissions to the Office of Purchases may be accessible as public records, pursuant to Title 38, Chapter 2 of the General Laws, absent specific notice that portions of such submittals may contain confidential or proprietary

information, such that public access to those items should be withheld, and except as otherwise provided for pursuant to R.I.G.L 37-2-18 (a)-(h) "Competitive Sealed Bidding".

16. **PRODUCT EVALUATION** - In all specifications, the words "or equal" are understood after each article when manufacturer's name or catalog are referenced. If bidding on items other than those specified, the bidder must, in every instance, give the trade designation of the article, manufacturer's name and detailed specifications of the item the bidder proposes to furnish; otherwise, the bid will be construed as submitted on the identical commodity described in the detailed specifications. The Purchasing Agent reserves the right to determine whether or not the item submitted is the approved equal the detailed specifications.

a. Any objections to specifications must be filed by a bidder, in writing, with the Purchasing Agent at least 96 hours before the time of bid opening to enable the Office of Purchases to properly investigate the objections.

b. All standards are minimum standards except as otherwise provided for in the Request or Contract.

c. Samples must be submitted to the Office of Purchases in accordance with the terms of the proposals and detailed specifications. Samples must be furnished free of charge and must be accompanied by descriptive memorandum invoices indicating whether or not the bidder desires their return and specifying the address to which they are to be returned (at the bidder's risk and expense), provided they have not been used or made useless by tests; and absent instructions, the samples shall be considered to be abandoned. Award samples may be held for comparison with deliveries.

d. All samples submitted are subject to test by any laboratory the State Purchasing Agent may designate.

17. **PRODUCT ACCEPTANCE** - All merchandise offered or otherwise provided shall be new, of prime manufacture, and of first quality unless otherwise specified by the State. The State reserves the right to reject all nonconforming goods, and to cause their return for credit or replacement, at the State's option. Contract deliverables specified for procurements of services shall be construed to be work products, and subject to the provisions of this section.

a. Failure by the State to discover latent defect(s) or concealed damage or nonconformance shall not foreclose the State's right to subsequently reject the goods in question.

b. Formal or informal acceptance by the State of non-conforming goods shall not constitute a precedent for successive receipts or procurements.

c. Where the contractor fails to promptly cure the defect or replace the goods, the State reserves the right to cancel the Purchase Order, contract with a different contractor, and to invoice the original contractor for any differential in price over the original contract price.

d. When materials, equipment or supplies are rejected, the same must be removed by the contractor from the premises of the State Agency within forty-eight (48) hours of

notification. Rejected items left longer than two days will be regarded as abandoned and the State shall have the right to dispose of them as its own property.

18. **PRODUCT WARRANTIES** - All product or service warranties normally offered by the contractor or bidder shall accrue to the State's benefit, in addition to any special requirements which may be imposed by the State. Every unit delivered must be guaranteed against faulty material and workmanship for a period of one year unless otherwise specified, and the State may, in the event of failure, order its replacement, repair, or return for full credit, at its sole option.

19. **PAYMENT** - Unless otherwise provided for by the Request or Contract, payment shall not be made until delivery has been made, or services performed, in full, and accepted. Payment shall not be due prior to thirty (30) working days following the latest of completion, acceptance, or the rendering of a properly submitted invoice.

a. Payment terms other than the foregoing may be rejected as being nonresponsive.

b. No partial shipments will be accepted, unless provided for by the Request or Contract.

c. Where a question of quality is involved, payment in whole or part against which to charge back any adjustment required, shall be withheld at the direction of the Purchasing Agent. In the event a cash discount is stipulated, the withholding of payments, as herein described, will not deprive the State from taking such discount.

d. Payments for used portion of inferior delivery will be made by the State on an adjusted price basis.

e. Payments on contracts under architectural or engineering supervision must be accompanied by a Certificate of Payment and Statement of Account signed by the architect or engineer and submitted to the Agency involved for approval.

20. **THIRD PARTY PAYMENTS** - The State recognizes no assigned or collateral rights to any purchase agreement except as may be expressly provided for in the bid or contract documents, and will not accede to any request for third party or joint payment(s), except as provided for in specific orders by a court of competent jurisdiction, or by express written permission of the Purchasing Agent. Where an offer is contingent upon such payment(s), the offeror is obligated to serve affirmative notice in his bid submission.

21. **SET-OFF AGAINST PAYMENTS** - Payments due the contractor shall be subject to reduction by the State Controller equal to the amount of unpaid and delinquent state taxes (or other just debt owed to the State), except where notice of delinquency has not been served or while the matter is pending in hearing or from any appeal therefrom.

22. **CLAIMS** - Any claim against a contractor may be deducted by the State from any money due him in the same or other transactions. If no deduction is made in such fashion, the contractor shall pay the State the amount of such claim on demand. Submission of a voucher and payment, thereof, by the State shall not preclude the Purchasing Agent from demanding a price adjustment in any case when the commodity delivered is later found to deviate from the specifications and proposal.

a. The Purchasing Agent may assess dollar damages against a vendor or contractor determined to be non-performing or otherwise in default of their contractual obligations equal to the cost of remedy incurred by the State, and make payment of such damages a condition for consideration for any subsequent award. Failure by the vendor or contractor to pay such damages shall constitute just cause for disqualification and rejection, suspension, or debarment.

23. STATE CONTROLLER'S CERTIFICATION OF FUNDING - Certification as to the availability of funds to support the procurement for the current fiscal year ending June 30th only. Where delivery or service requirements extend beyond the end of the current fiscal year, such extensions are subject to both the availability of appropriated funds and a determination of continued need.

24. UNUSED BALANCES - Unless otherwise specified, all unused Blanket Order quantities and/or unexpended funds shall be automatically canceled on the expiration of the specified term. Similarly, for orders encompassing more than one State fiscal year, unexpended balances of funding allotted for an individual fiscal year may be liquidated at the close of that fiscal year, at the State's sole option.

25. MINORITY BUSINESS ENTERPRISES - Pursuant to the provisions of Title 37 Chapter 14.1 of the General Laws, the State reserves the right to apply additional consideration to offers, and to direct awards to bidders other than the responsive bid representing the lowest price where:

a. the offer is fully responsive to the terms and conditions of the Request, and

b. the price offer is determined to be within a competitive range (not to exceed 5% higher than the lowest responsive price offer) for the product or service, and c. the firm making the offer has been certified by the R.I. Department of Economic Development to be a small business concern meeting the criteria established to be considered a Minority Business Enterprise. Ten per cent [10%] of the dollar value of the work performed against contracts for construction exceeding \$5,000 shall be performed by Minority Business Enterprises where it has been determined that subcontract opportunities exist, and where certified Minority Business Enterprises are available. A contractor may count towards its MBE, DBE, or WBE goals 60% of its expenditures for materials and supplies required under a contract and obtained from an MBE, DBE, or WBE regular dealer, and 100% of such expenditures when obtained from an MBE, DBE, or WBE manufacturer. Awards of this type shall be subject to approval, by the Director of Administration, of a Subcontracting Plan submitted by the bidder receiving the award.

26. PREVAILING WAGE REQUIREMENT - In accordance with Title 37 Chapter 13 of the General Laws of Rhode Island, payment of the general prevailing rate of per diem wages and the general prevailing rate for regular, overtime and other working conditions existing in the locality for each craft, mechanic, teamster, or type of workman needed to execute this work is a requirement for both contractors and subcontractors for all public works.

27. EQUAL OPPORTUNITY COMPLIANCE, HANDICAPPED ACCESS AND AFFIRMATIVE ACTION - Contractors of the State are required to demonstrate the

same commitment to equal opportunity as prevails under federal contracts controlled by Federal Executive Orders 11246, 11625, 11375 and 11830, and Title 28 Chapter 5.1 of the General Laws of Rhode Island. Affirmative action plans shall be submitted by the contractor for review by the State Equal Opportunity Office. A contractor's failure to abide by the rules, regulations, contract terms and compliance reporting provisions as established shall be grounds for forfeiture and penalties as shall be established, including but not limited to suspension.

28. DRUG-FREE WORKPLACE REQUIREMENT - In accordance with Executive Order No. 91-14, Contractors who do business with the State and their employees shall abide by the State's drug-free workplace policy and the contractor shall so attest by signing a certificate of compliance.

29. GOODS PRODUCED IN THE REPUBLIC OF SOUTH AFRICA – In accordance with Chapters 35-10-12 and 37-2-57 of the General Laws, goods which are known to be wholly produced in the Republic of South Africa may not be accepted for any procurement the State of Rhode Island; the offeror attests by his submission of a bid or offer, or acceptance of a purchase order or other contract, that these prohibitions do not apply to material or goods which form the basis for his offer or contract.

30. TAXES - The State of Rhode Island is exempt from payment of excise, transportation and sales tax imposed by the Federal or State Government. These taxes should not be included in the proposal price. Exemption Certificates will be furnished upon request.

31. INSURANCE - All construction contractors, independent tradesmen, or firms providing any type of maintenance, repair, or other type of service to be performed on state premises, buildings, or grounds are required to purchase and maintain coverage with a company or companies licensed to do business in the state as follows:

a. Comprehensive General Liability Insurance -

1) Bodily Injury \$1,000,000 each occurrence; \$1,000,000 annual aggregate

2) Property Damage \$500,000 each occurrence; \$500,000 annual aggregate

Independent Contractors

Contractual - including construction hold harmless and other types of contracts or agreements in effect for insured operations

Completed Operations

Personal Injury (with employee exclusion deleted)

b. Automobile Liability Insurance -

Combined Single Limit \$1,000,000 each occurrence

Bodily Injury

Property Damage, and in addition non-owned and/or hired vehicles and equipment

c. Workers' Compensation Insurance - Coverage B \$100,000

The Purchasing Agent reserves the right to consider and accept alternate forms and plans of insurance or to require additional or more extensive coverage for any individual requirement. Successful bidders shall provide certificates of coverage, reflecting the State of Rhode Island as an additional insured, to the Office of Purchases, forty-eight (48) hours prior to the commencement of work, as a condition of award. Failure to comply with this provision shall result in rejection of the offeror's bid.

32. BID SURETY - When requested, a bidder must furnish a Bid Bond or Certified Check for 5% of his bid, or for the stated amount shown in the solicitation. Bid Bonds must be executed by a reliable Surety Company authorized to do business in the State of Rhode Island. Failure to provide Bid Surety with bid may be cause for rejection of bid. The Bid Surety of any three bidders in contention will be held until an award has been made according to the specifications of each proposal. All others will be returned by mail within 48 hours following the bid opening. Upon award of a contract, the remaining sureties will be returned by mail unless instructed to do otherwise.

33. PERFORMANCE AND LABOR AND PAYMENT BONDS – A performance bond and labor and payment bond of up to 100% of an award may be required by the Purchasing Agent. Bonds must meet the following requirements:

- a. Corporation: The Bond must be signed by an official of the corporation above his official title and the corporate seal must be affixed over his signature.
- b. Firm or Partnership: The Bond must be signed by all of the partners and must indicate that they are "Doing Business As (name of firm)."
- c. Individual: The Bond must be signed by the individual owning the business and indicate "Owner."
- d. The Surety Company executing the Bond must be licensed to do business in the State of Rhode Island or Bond must be countersigned by a company so licensed.
- e. The Bond must be signed by an official of the Surety Company and the corporate seal must be affixed over his signature.
- f. Signatures of two witnesses for both the principal and the Surety must appear on the Bond.
- g. A Power of Attorney for the official signing of the Bond for the Surety Company must be submitted with the Bond.

34. DEFAULT AND CANCELLATION - A contract may be canceled or annulled at the contractor's expense upon non-performance of contract, or breach, by the contractor, of any of his obligations. Failure of contractor to cure such non-performance or breach within ten working days after the receipt of notice, shall be sufficient cause for the cancellation of the contract in question, the cancellation of all outstanding contracts or sub-contracts held by the contractor, and the suspension or debarment of the contractor from future procurements.

- a. Failure of a contractor to deliver or perform within the time specified, or within reasonable time as interpreted by the Purchasing Agent or failure to make replacement of rejected articles, when so requested, immediately or as directed by the Purchasing Agent, will cause the Purchasing Agent to purchase in the open market to replace those

rejected or not delivered. The Purchasing Agent reserves the right to authorize immediate purchase in the open market against rejections on any contract when necessary. On all such purchases, the contractor, or his surety, agrees to promptly reimburse the State for excess costs occasioned by such default. Should the cost be less, the contractor shall have no claim to the difference.

b. A contractor who fails to commence within the time specified or complete an award made for repairs, alterations, construction, or any other service will be considered in default of contract. The Purchasing Agent may contract for completion of the work with another contractor and seek recourse from the defaulting contractor or his surety.

c. If contractor consistently fails to deliver quantities or otherwise perform as specified, the Purchasing Agent reserves the right to cancel the contract and purchase the balance in the open market at the contractor's expense.

35. INDEMNITY - The contractor guarantees:

a. To save the State, its agents and employees, harmless from any liability imposed upon the State arising from the negligence, either active or passive, of the contractor, as well as for the use of any copyrighted or non-copyrighted composition, secret process, patented or unpatented invention, article or appliance furnished or used in the performance of the contract of which the contractor is not the patentee, assignee or licensee.

b. To pay for all permits, licenses and fees and give all notices and comply with all laws, ordinances, rules and regulations of the city or town in which the installation is to be made and of the State of Rhode Island.

c. That the equipment offered is standard new equipment, latest model of regular stock product with all parts regularly used with the type of equipment offered; also, that no attachment or part has been substituted or applied contrary to manufacturer's recommendations and standard practice.

36. CONTRACTOR'S OBLIGATIONS - In addition to the specific requirements of the contract, construction and building repair contractors bear the following standard responsibilities:

a. To furnish adequate protection from damage for all work and to repair damages of any kind, for which he or his workmen are responsible, to the building or equipment, to his own work, or to the work of other contractors;

b. To clear and remove all debris and rubbish resulting from his work from time to time, as directed or required, a completion of the work leave the premises in a neat unobstructed condition, broom clean, and in satisfactory order and repair;

c. To store equipment, supplies, and material at the site only upon approval by the State, and at his own risk;

d. To perform all work so as to cause the least inconvenience to the State, and with proper consideration for the rights of other contractors and workmen;

e. To acquaint themselves with conditions to be found at the site, and to assume responsibility for the appropriate dispatching of equipment and supervision of his employees during the conduct of the work; and

f. To ensure that his employees are instructed with respect to special regulations, policies, and procedures in effect for any State facility or site, and that they comply with such rules.

37. FORCE MAJEURE - All orders shall be filled by the contractor with reasonable promptness, but the contractor shall not be held responsible for any losses resulting if the fulfillment of the terms of the contract shall be delayed or prevented by wars, acts of public enemies, strikes, fires, floods, acts of God, or for any other acts not within the control of the contractor and which by the exercise of reasonable diligence, the contractor is unable to prevent.

Appendix B: Notice to Department of Human Services Service Providers of Their Responsibilities under Title VI of the Civil Rights Act of 1964

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES NOTICE TO DEPARTMENT OF HUMAN SERVICES SERVICE PROVIDERS OF THEIR RESPONSIBILITIES UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

PUBLIC AND PRIVATE AGENCIES, ORGANIZATIONS, INSTITUTIONS, AND PERSONS THAT RECEIVE FEDERAL FINANCIAL ASSISTANCE THROUGH THE DEPARTMENT OF HUMAN SERVICES (DHS) ARE SUBJECT TO THE PROVISIONS OF TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 AND THE IMPLEMENTING REGULATIONS OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS), WHICH IS LOCATED AT 45 CFR, PART 80. DHS CONTRACTS WITH SERVICE PROVIDERS INCLUDE A PROVIDER'S ASSURANCE THAT IN COMPLIANCE WITH TITLE VI AND THE IMPLEMENTING REGULATIONS, NO PERSON SHALL BE EXCLUDED FROM PARTICIPATION IN, DENIED THE BENEFITS OF, OR BE OTHERWISE SUBJECTED TO DISCRIMINATION IN ITS PROGRAMS AND ACTIVITIES ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN.

IN FISCAL YEAR 1983, DHS BEGAN TO REVIEW ITS SERVICE PROVIDERS TO ASSURE THAT THEY ARE COMPLYING WITH THESE REQUIREMENTS.

IT IS THE RESPONSIBILITY OF EACH SERVICE PROVIDER TO ACQUAINT ITSELF WITH ALL OF THE PROVISIONS OF THE TITLE VI REGULATIONS. A COPY OF THE REGULATIONS IS AVAILABLE UPON REQUEST FROM THE COMMUNITY RELATIONS LIAISON OFFICER, DEPARTMENT OF HUMAN SERVICES, 600 NEW LONDON AVENUE, CRANSTON, RI 02920; TELEPHONE NUMBER: (401) 462-2130.

THE REGULATIONS ADDRESS THE FOLLOWING TOPICS:

SECTION:

- 80.1 PURPOSE
- 80.2 APPLICATION OF THIS REGULATION
- 80.3 DISCRIMINATION PROHIBITED
- 80.4 ASSURANCES REQUIRED
- 80.5 ILLUSTRATIVE APPLICATIONS
- 80.6 COMPLIANCE INFORMATION
- 80.7 CONDUCT OF INVESTIGATIONS
- 80.8 PROCEDURE FOR EFFECTING COMPLIANCE
- 80.9 HEARINGS
- 80.10 DECISIONS AND NOTICES
- 80.11 JUDICIAL REVIEW

80.12 EFFECT ON OTHER REGULATIONS; FORMS AND INSTRUCTIONS

80.13 DEFINITION

Appendix C: Notice to Department of Human Services Service Providers of Their Responsibilities under Section 504 of the Rehabilitation Act of 1973

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

NOTICE TO DEPARTMENT OF HUMAN SERVICES SERVICE PROVIDERS OF THEIR RESPONSIBILITIES UNDER SECTION 504 OF THE REHABILITATION ACT OF 1973

PUBLIC AND PRIVATE AGENCIES, ORGANIZATIONS, INSTITUTIONS, AND PERSONS THAT RECEIVE FEDERAL FINANCIAL ASSISTANCE THROUGH THE DEPARTMENT OF HUMAN SERVICES (DHS) ARE SUBJECT TO THE PROVISIONS OF SECTION 504 OF THE REHABILITATION ACT OF 1973 AND THE IMPLEMENTING REGULATIONS OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS), WHICH IS LOCATED AT 45 CFR, PART 84. DHS CONTRACTS WITH SERVICE PROVIDERS INCLUDE THE PROVIDER'S ASSURANCE THAT IT WILL COMPLY WITH SECTION 504 OF THE REGULATIONS, WHICH PROHIBITS DISCRIMINATION AGAINST HANDICAPPED PERSONS IN PROVIDING HEALTH, WELFARE, OR OTHER SOCIAL SERVICES OR BENEFITS.

IN FISCAL YEAR 1983 DHS BEGAN TO REVIEW ITS SERVICES PROVIDERS TO ASSURE THAT THEY ARE COMPLYING WITH THESE REQUIREMENTS.

IT IS THE RESPONSIBILITY OF EACH SERVICE PROVIDER TO ACQUAINT ITSELF WITH ALL OF THE PROVISIONS OF THE SECTION 504 REGULATIONS. A COPY OF THE REGULATIONS, TOGETHER WITH AN AUGUST 14, 1978 POLICY INTERPRETATION OF GENERAL INTEREST TO PROVIDERS OF HEALTH, WELFARE, OR OTHER SOCIAL SERVICES OR BENEFITS, IS AVAILABLE UPON REQUEST FROM THE COMMUNITY RELATIONS LIAISON OFFICER, DEPARTMENT OF HUMAN SERVICES, 600 NEW LONDON AVENUE, CRANSTON, RI 02920; TELEPHONE NUMBER (401) 462-2130.

PROVIDERS SHOULD PAY PARTICULAR ATTENTION TO SUBPARTS A, B, C, AND F OF THE REGULATIONS WHICH PERTAIN TO THE FOLLOWING:

SUBPART A - GENERAL PROVISIONS

SECTION:

- | | |
|-------|---|
| 84.1 | PURPOSE |
| 84.2 | APPLICATIONS |
| 84.3 | DEFINITIONS |
| 84.4 | DISCRIMINATION PROHIBITED |
| 84.5 | ASSURANCE REQUIRED |
| 84.6 | REMEDIAL ACTION, VOLUNTARY ACTION, AND SELF-EVALUATION |
| 84.7 | DESIGNATION OF RESPONSIBLE EMPLOYEE AND ADOPTIVE GRIEVANCE PROCEDURES |
| 84.8 | NOTICE |
| 84.9 | ADMINISTRATIVE REQUIREMENTS FOR SMALL RECIPIENTS |
| 84.10 | EFFECT OF STATE OR LOCAL LAW OR OTHER REQUIREMENTS AND EFFECT OF EMPLOYMENT |

OPPORTUNITIES

SUBPART B - EMPLOYMENT PRACTICES

SECTION:

- 84.11 DISCRIMINATION PROHIBITED
- 84.12 REASONABLE ACCOMMODATION
- 84.13 EMPLOYMENT CRITERIA
- 84.14 PREEMPLOYMENT INQUIRIES
- 84.15 - 84.20 (RESERVED)

SUBPART C - PROGRAM ACCESSIBILITY

SECTION:

- 84.21 DISCRIMINATION PROHIBITED
- 84.22 EXISTING FACILITIES
- 84.23 NEW CONSTRUCTION
- 84.24 - 84.30 (RESERVED)

SUBPART F - HEALTH, WELFARE, AND SOCIAL SERVICES

SECTION:

- 84.51 APPLICATION OF THIS SUBPART
- 84.52 HEALTH, WELFARE, AND OTHER SOCIAL SERVICES
- 84.53 DRUG AND ALCOHOL ADDICTS

**Appendix D: Drug-Free Workplace Policy and Contractor
Certificate of Compliance (Attached on next page)**

DRUG-FREE WORKPLACE POLICY

DRUG USE AND ABUSE AT THE WORKPLACE OR WHILE ON DUTY ARE SUBJECTS OF IMMEDIATE CONCERN IN OUR SOCIETY. THESE PROBLEMS ARE EXTREMELY COMPLEX AND ONES FOR WHICH THERE ARE NO EASY SOLUTIONS. FROM A SAFETY PERSPECTIVE, THE USERS OF DRUGS MAY IMPAIR THE WELL-BEING OF ALL EMPLOYEES, THE PUBLIC AT LARGE, AND RESULT IN DAMAGE TO PROPERTY. THEREFORE, IT IS THE POLICY OF THE STATE THAT THE UNLAWFUL MANUFACTURE, DISTRIBUTION, DISPENSATION, POSSESSION, OR USE OF A CONTROLLED SUBSTANCE IS PROHIBITED IN THE WORKPLACE. ANY EMPLOYEE(S) VIOLATING THIS POLICY WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION. AN EMPLOYEE MAY ALSO BE DISCHARGED OR OTHERWISE DISCIPLINED FOR A CONVICTION INVOLVING ILLICIT DRUG BEHAVIOR, REGARDLESS OF WHETHER THE EMPLOYEE S CONDUCT WAS DETECTED WITHIN EMPLOYMENT HOURS OR WHETHER HIS/HER ACTIONS WERE CONNECTED IN ANY WAY WITH HIS OR HER EMPLOYMENT. THE SPECIFICS OF THIS POLICY ARE AS FOLLOWS:

ANY UNAUTHORIZED EMPLOYEE WHO GIVES OR IN ANY WAY TRANSFERS A CONTROLLED SUBSTANCE TO ANOTHER PERSON OR SELLS OR MANUFACTURES A CONTROLLED SUBSTANCE WHILE ON DUTY, REGARDLESS OF WHETHER THE EMPLOYEE IS ON OR OFF THE PREMISES OF THE EMPLOYER WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION.

THE TERM "CONTROLLED SUBSTANCE" MEANS ANY DRUGS LISTED IN 21 USC, SECTION 812 AND OTHER FEDERAL REGULATIONS. GENERALLY, ALL ILLEGAL DRUGS AND SUBSTANCES ARE INCLUDED, SUCH AS MARIJUANA, HEROIN, MORPHINE, COCAINE, CODEINE OR OPIUM ADDITIVES, LSD, DMT, STP, AMPHETAMINES, METHAMPHETAMINES, AND BARBITURATES.

EACH EMPLOYEE IS REQUIRED BY LAW TO INFORM THE AGENCY WITHIN FIVE (5) DAYS AFTER HE/SHE IS CONVICTED FOR VIOLATION OF ANY FEDERAL OR STATE CRIMINAL DRUG STATUTE. A CONVICTION MEANS A FINDING OF GUILT (INCLUDING A PLEA OF NOLO CONTENDERE) OR THE IMPOSITION OF A SENTENCE BY A JUDGE OR JURY IN ANY FEDERAL OR STATE COURT.

THE EMPLOYER (THE HIRING AUTHORITY) WILL BE RESPONSIBLE FOR REPORTING CONVICTION(S) TO THE APPROPRIATE FEDERAL GRANTING SOURCE WITHIN TEN (10) DAYS AFTER RECEIVING NOTICE FROM THE EMPLOYEE OR OTHERWISE RECEIVES ACTUAL NOTICE OF SUCH CONVICTION(S). ALL CONVICTION(S) MUST BE REPORTED IN WRITING TO THE OFFICE OF PERSONNEL ADMINISTRATION (OPA) WITHIN THE SAME TIME FRAME.

IF AN EMPLOYEE IS CONVICTED OF VIOLATING ANY CRIMINAL DRUG STATUTE WHILE ON DUTY, HE/SHE WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION. CONVICTION(S) WHILE OFF DUTY MAY RESULT IN DISCIPLINE OR DISCHARGE.

THE STATE ENCOURAGES ANY EMPLOYEE WITH A DRUG ABUSE PROBLEM TO SEEK ASSISTANCE FROM THE RHODE ISLAND EMPLOYEE ASSISTANCE PROGRAM (RIEAP). YOUR DEPARTMENT PERSONNEL OFFICER HAS MORE INFORMATION ON RIEAP.

THE LAW REQUIRES ALL EMPLOYEES TO ABIDE BY THIS POLICY.

EMPLOYEE RETAIN THIS COPY

DRUG-FREE WORKPLACE POLICY
CONTRACTOR CERTIFICATE OF COMPLIANCE

I,
_____, A CONTRACTOR DOING BUSINESS WITH THE STATE OF RHODE ISLAND, HEREBY
ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE STATE'S POLICY REGARDING THE
MAINTENANCE OF A **DRUG-FREE WORKPLACE**. I HAVE BEEN INFORMED THAT THE UNLAWFUL
MANUFACTURE, DISTRIBUTION, DISPENSATION, POSSESSION, OR USE OF A CONTROLLED
SUBSTANCE (TO INCLUDE BUT NOT LIMITED TO SUCH DRUGS AS MARIJUANA, HEROIN,
COCAINE, PCP, AND CRACK, AND MAY ALSO INCLUDE LEGAL DRUGS WHICH MAY BE
PRESCRIBED BY A LICENSED PHYSICIAN IF THEY ARE ABUSED), IS PROHIBITED ON THE
STATE'S PREMISES OR WHILE CONDUCTING STATE BUSINESS. I ACKNOWLEDGE THAT MY
EMPLOYEES MUST REPORT FOR WORK IN A FIT CONDITION TO PERFORM THEIR DUTIES.

AS A CONDITION FOR CONTRACTING WITH THE STATE, AS A RESULT OF THE FEDERAL
OMNIBUS DRUG ACT, I WILL REQUIRE MY EMPLOYEES TO ABIDE BY THE STATE'S POLICY.
FURTHER, I RECOGNIZE THAT ANY VIOLATION OF THIS POLICY MAY RESULT IN
TERMINATION OF THE CONTRACT.

AUTHORIZED AGENT/SIGNATURE
PROVIDER

DATE

Appendix E: Subcontractor Compliance (Attached on next page)

SUBCONTRACTOR COMPLIANCE

I,

A CONTRACTOR DOING BUSINESS WITH THE STATE OF RHODE ISLAND, HEREBY CERTIFY THAT ALL APPROVED SUBCONTRACTORS PERFORMING SERVICES UNDER THE TERMS OF THIS AGREEMENT WILL HAVE EXECUTED WRITTEN CONTRACTS WITH THIS AGENCY, AND ALL CONTRACTS WILL BE MAINTAINED ON FILE AND PRODUCED UPON REQUEST. ALL CONTRACTS MUST CONTAIN LANGUAGE IDENTICAL TO THE PROVISIONS OF THIS AGREEMENT AS FOLLOWS:

PAR.	☐	NONLIABILITY FOR PERSONAL INJURIES
PAR.	☐	NONDISCRIMINATION IN EMPLOYMENT AND SERVICES
PAR.	☐	DRUG-FREE WORKPLACE POLICY

AUTHORIZED AGENT/SIGNATURE
PROVIDER

DATE

Appendix F: Certification Regarding Environmental Tobacco Smoke (Attached on next page)

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

PUBLIC LAW 103-227, PART C - ENVIRONMENTAL TOBACCO SMOKE, ALSO KNOWN AS THE PRO-CHILDREN ACT OF 1994 (**ACT**), REQUIRES THAT SMOKING NOT BE PERMITTED IN ANY PORTION OF ANY INDOOR FACILITY OWNED OR LEASED OR CONTRACTED FOR BY AN ENTITY AND USED ROUTINELY OR REGULARLY FOR THE PROVISION OF HEALTH, DAY CARE, EDUCATION, OR LIBRARY SERVICES TO CHILDREN UNDER THE AGE OF 18, IF THE SERVICES ARE FUNDED BY FEDERAL PROGRAMS EITHER DIRECTLY OR THROUGH STATE OR LOCAL GOVERNMENTS, BY FEDERAL GRANT, CONTRACT, LOAN, OR LOAN GUARANTEE. THE LAW DOES NOT APPLY TO CHILDREN'S SERVICES PROVIDED IN PRIVATE RESIDENCES, FACILITIES FUNDED SOLELY BY MEDICARE OR MEDICAID FUNDS, AND PORTIONS OF FACILITIES USED FOR INPATIENT DRUG OR ALCOHOL TREATMENT. FAILURE TO COMPLY WITH THE PROVISIONS OF THE LAW MAY RESULT IN THE IMPOSITION OF A CIVIL MONETARY PENALTY OF UP TO \$1000 PER DAY AND/OR THE IMPOSITION OF AN ADMINISTRATIVE COMPLIANCE ORDER ON THE RESPONSIBLE ENTITY.

BY SIGNING AND SUBMITTING THIS APPLICATION THE APPLICANT/GRANTEE CERTIFIES THAT IT WILL COMPLY WITH THE REQUIREMENTS OF THE **ACT**. THE APPLICANT/GRANTEE FURTHER AGREES THAT IT WILL REQUIRE THE LANGUAGE OF THIS CERTIFICATION BE INCLUDED IN ANY SUBAWARDS WHICH CONTAIN PROVISIONS FOR CHILDREN'S SERVICES AND THAT ALL SUBGRANTEES SHALL CERTIFY ACCORDINGLY.

AUTHORIZED AGENT / SIGNATURE
PROVIDER

DATE

Appendix G: Instructions for Certification Regarding Debarment, Suspension, and Other Responsibility Matters – Primary Covered Transactions and Certification

INSTRUCTIONS FOR CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS - PRIMARY COVERED TRANSACTIONS

BY SIGNING AND SUBMITTING THIS PROPOSAL, THE PROSPECTIVE PRIMARY PARTICIPANT IS PROVIDING THE CERTIFICATION SET OUT BELOW.

THE INABILITY OF A PERSON TO PROVIDE THE CERTIFICATION REQUIRED BELOW WILL NOT NECESSARILY RESULT IN DENIAL OF PARTICIPATION IN THIS COVERED TRANSACTION. IF NECESSARY, THE PROSPECTIVE PARTICIPANT SHALL SUBMIT AN EXPLANATION OF WHY IT CANNOT PROVIDE THE CERTIFICATION. THE CERTIFICATION OR EXPLANATION WILL BE CONSIDERED IN CONNECTION WITH THE DEPARTMENT'S DETERMINATION WHETHER TO ENTER INTO THIS TRANSACTION. HOWEVER, FAILURE OF THE PROSPECTIVE PRIMARY PARTICIPANT TO FURNISH A CERTIFICATION OR EXPLANATION SHALL DISQUALIFY SUCH PERSON FROM PARTICIPATION IN THIS TRANSACTION.

THE CERTIFICATION IN THIS CLAUSE IS A MATERIAL REPRESENTATION OF FACT UPON WHICH RELIANCE WAS PLACED WHEN THE DEPARTMENT DETERMINED THAT THE PROSPECTIVE PRIMARY PARTICIPANT KNOWINGLY RENDERED AN ERRONEOUS CERTIFICATION, IN ADDITION TO OTHER REMEDIES AVAILABLE TO THE DEPARTMENT. THE DEPARTMENT MAY TERMINATE THIS TRANSACTION FOR CAUSE OR DEFAULT.

THE PROSPECTIVE PRIMARY PARTICIPANT SHALL PROVIDE IMMEDIATE WRITTEN NOTICE TO THE DEPARTMENT IF AT ANY TIME THE PROSPECTIVE PRIMARY PARTICIPANT LEARNS THAT ITS CERTIFICATION WAS ERRONEOUS WHEN SUBMITTED OR HAS BECOME ERRONEOUS BY REASON OF CHANGED CIRCUMSTANCES.

THE TERMS "COVERED TRANSACTION," "DEBARRED," "SUSPENDED," "INELIGIBLE," "LOWER TIER COVERED TRANSACTION," "PARTICIPANT," "PERSON," "PRIMARY COVERED TRANSACTION," "PRINCIPAL," "PROPOSAL," AND "VOLUNTARILY EXCLUDED," AS USED IN THIS CLAUSE, HAVE THE MEANINGS SET OUT IN THE DEFINITIONS AND COVERAGE SECTIONS OF THE RULES IMPLEMENTING EXECUTIVE ORDER 12549: 45 CFR PART 76.

THE PROSPECTIVE PRIMARY PARTICIPANT AGREES BY SUBMITTING THIS PROPOSAL THAT, SHOULD THE PROPOSED COVERED TRANSACTION BE ENTERED INTO, IT SHALL NOT KNOWINGLY ENTER INTO ANY LOWER TIER COVERED TRANSACTION WITH A PERSON WHO IS DEBARRED, SUSPENDED, DECLARED INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM PARTICIPATION IN THIS COVERED TRANSACTION, UNLESS AUTHORIZED BY THE DEPARTMENT.

THE PROSPECTIVE PRIMARY PARTICIPANT FURTHER AGREES BY SUBMITTING THIS PROPOSAL THAT IT WILL INCLUDE THE CLAUSE TITLED CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION - LOWER TIER COVERED TRANSACTIONS, PROVIDED BY DHS, WITHOUT MODIFICATION, IN ALL LOWER TIER COVERED TRANSACTIONS AND IN ALL SOLICITATIONS FOR LOWER TIER COVERED TRANSACTIONS.

A PARTICIPANT IN A COVERED TRANSACTION MAY RELY UPON A CERTIFICATION OF A

PROSPECTIVE PARTICIPANT IN A LOWER TIER COVERED TRANSACTION THAT IS NOT DEBARRED, SUSPENDED, INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM THE COVERED TRANSACTION, UNLESS IT KNOWS THAT THE CERTIFICATION IS ERRONEOUS. A PARTICIPANT MAY DECIDE THE METHOD AND FREQUENCY BY WHICH IT DETERMINES THE ELIGIBILITY OF ITS PRINCIPALS. EACH PARTICIPANT MAY, BUT IS NOT REQUIRED TO, CHECK THE NONPROCUREMENT LIST (OF EXCLUDED PARTIES).

NOTHING CONTAINED IN THE FOREGOING SHALL BE CONSTRUED TO REQUIRE ESTABLISHMENT OF A SYSTEM OF RECORDS IN ORDER TO RENDER IN GOOD FAITH THE CERTIFICATION REQUIRED BY THIS CLAUSE. THE KNOWLEDGE AND INFORMATION OF A PARTICIPANT IS NOT REQUIRED TO EXCEED THAT WHICH IS NORMALLY POSSESSED BY AS PRUDENT PERSON IN THE ORDINARY COURSE OF BUSINESS DEALINGS.

EXCEPT FOR TRANSACTIONS AUTHORIZED UNDER PARAGRAPH 6 OF THESE INSTRUCTIONS, IF A PARTICIPANT IN A COVERED TRANSACTION KNOWINGLY ENTERS INTO A LOWER TIER COVERED TRANSACTION WITH A PERSON WHO IS SUSPENDED, DEBARRED, INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM PARTICIPATION IN THIS TRANSACTION, IN ADDITION TO OTHER REMEDIES AVAILABLE TO THE FEDERAL GOVERNMENT, THE DEPARTMENT MAY TERMINATE THIS TRANSACTION FOR CAUSE OF DEFAULT.

**CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY
MATTERS - PRIMARY COVERED TRANSACTIONS**

1. THE PROSPECTIVE PRIMARY PARTICIPANT CERTIFIES TO THE BEST OF ITS KNOWLEDGE AND BELIEF, THAT IT AND ITS PRINCIPALS:
ARE NOT PRESENTLY DEBARRED, SUSPENDED, PROPOSED FOR DEBARMENT, DECLARED INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM COVERED TRANSACTIONS BY ANY FEDERAL DEPARTMENT OR AGENCY;
HAVE NOT WITHIN A THREE-YEAR PERIOD PRECEDING THIS PROPOSAL BEEN CONVICTED OF OR HAD A CIVIL JUDGEMENT RENDERED AGAINST THEM FOR COMMISSION OF FRAUD OR A CRIMINAL OFFENSE IN CONNECTION WITH OBTAINING, ATTEMPTING TO OBTAIN, OR PERFORMING A PUBLIC (FEDERAL, STATE OR LOCAL) TRANSACTION OR CONTRACT UNDER PUBLIC TRANSACTION; VIOLATION OF FEDERAL OR STATE ANTITRUST STATUTES OR COMMISSION OF EMBEZZLEMENT, THEFT, FORGERY, BRIBERY, FALSIFICATION OR DESTRUCTION OF RECORDS, MAKING FALSE STATEMENTS, OR RECEIVING STOLEN PROPERTY;
 3. ARE NOT PRESENTLY INDICTED FOR OTHERWISE CRIMINALLY OR CIVILLY CHARGED BY A GOVERNMENTAL ENTITY (FEDERAL, STATE OR LOCAL) WITH COMMISSION OF ANY OF THE OFFENSES ENUMERATED IN PARAGRAPH (1) (B) OF THIS CERTIFICATION; AND
 4. HAVE NOT WITHIN A THREE-YEAR PERIOD PRECEDING THIS APPLICATION/PROPOSAL HAD ONE OR MORE PUBLIC TRANSACTIONS (FEDERAL, STATE OR LOCAL) TERMINATED FOR CAUSE OR DEFAULT.
- WHERE THE PROSPECTIVE PRIMARY PARTICIPANT IS UNABLE TO CERTIFY TO ANY OF THE STATEMENTS IN THIS CERTIFICATION, SUCH PROSPECTIVE PARTICIPANT SHALL ATTACH AN EXPLANATION TO THIS PROPOSAL

**AUTHORIZED AGENT/SIGNATURE
PROVIDER**

DATE

Appendix H – W9 Form (Attached on next page)

State of Rhode Island
PAYER'S REQUEST FOR TAXPAYER
IDENTIFICATION NUMBER AND CERTIFICATION

THE IRS REQUIRES THAT YOU FURNISH YOUR TAXPAYER IDENTIFICATION NUMBER TO US. FAILURE TO PROVIDE THIS INFORMATION CAN RESULT IN A \$50 PENALTY BY THE IRS. IF YOU ARE AN INDIVIDUAL, PLEASE PROVIDE US WITH YOUR SOCIAL SECURITY NUMBER (SSN) IN THE SPACE INDICATED BELOW. IF YOU ARE A COMPANY OR A CORPORATION, PLEASE PROVIDE US WITH YOUR EMPLOYER IDENTIFICATION NUMBER (EIN) WHERE INDICATED.

Taxpayer Identification Number (T.I.N.)

Enter your taxpayer identification number in Social Security No. (SSN) Employer ID No. (EIN) the appropriate box. For most individuals, this is your social security number.

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NAME**ADDRESS****(REMITTANCE ADDRESS, IF DIFFERENT)****CITY, STATE AND ZIP CODE****CERTIFICATION:** Under penalties of perjury, I certify that:

- (1) The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), **and**
 (2) I am not subject to backup withholding because either: (A) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (B) the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions -- You must cross out item (2) above if you have been notified by the IRS that you are subject to backup withholding because of under-reporting interest or dividends on your tax return. However, if after being notified by IRS that you were subject to backup withholding you received another notification from IRS that you are no longer subject to backup withholding, do not cross out item (2).

BUSINESS DESIGNATION:

Please Check One: Individual ☐ Medical Services Corporation ☐ Government Non-Profit Corporation ☐
 Partnership ☐ Corporation ☐ Trust Estate ☐ Legal Services Corporation ☐

PLEASE SIGN HERE

SIGNATURE _____ TITLE _____ DATE _____ TEL NO. _____

NAME: Be sure to enter your full and correct name as listed in the IRS file for you or your business.

ADDRESS, CITY, STATE AND ZIP CODE: Enter your primary business address and remittance address if different from your primary address). If you operate a business at more than one location, adhere to the following:

- 1) Same T.I.N. with more than one location -- attach a list of location addresses with remittance address for each location and indicate to which location the year-end tax information return should be mailed.
- 2) Different T.I.N. for each different location -- submit a completed W-9 form for each T.I.N. and location. (One year-end tax information return will be reported for each T.I.N. and remittance address.)

CERTIFICATION -- Sign the certification, enter your title, date, and your telephone number (including area code and extension).**BUSINESS TYPE CHECK-OFF** --Check the appropriate box for the type of business ownership.

Appendix I: Glossary of Acronyms

Acronym	Description
A&C	Office of Accounts & Control
ACA	Affordable Care Act
ACG	Adjusted Clinical Group
ACS	Affiliated Computer Services Inc
ADAP	AIDS Drug Assistance Program
APD	Advanced Planning Document
BCCTP	Breast and Cervical Cancer Treatment and Screening Programs
BCI	National Criminal History Background Check
BCM	Business Capability Matrix
BHDDH	Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
BHP	Basic Health Plan
CAP	Corrective Action Plan
CHIP	Children's Health Insurance Program
CHOICES MMIS	The Medicaid Data Warehouse used as a repository for data to support business analysis and reporting.
CMS	Centers for Medicare and Medicaid Services
CNOM	Costs Not Otherwise Matchable
COTS	Commercial Off the Shelf
CRM	Customer Relationship Management
CSHCN	Children with Special Health Care Needs
DBM	Dental Benefits Manager
DBMS	Database Management System
DCYF	Department of Children, Youth and Families
DD	Design Documentation
DDI	Develop, Design, Implementation
DEA	Division of Elderly Affairs
DED	Delivery Expectation Document

Acronym	Description
DHS	Department of Human Services
DLT	Department of Labor and Training
DMV	Department of Motor Vehicles
DOA	Department of Administration
DOH	Department of Health
DoIT	Department of Information Technology
DSH	Disproportionate Share Hospital
DURS	Drug Utilization Review and Surveillance
EHR	Electronic Health Record
EDI	Electronic Data Interchange
EDS	Electronic Data Systems
EFT	Electronic Funds Transfer
EI	Early Intervention
EMC	Electronic Management Claims
EOHHS	Executive Office of Health and Human Services
EPSDT	Early Periodic Screening, Diagnosis and Treatment
ERP	Enterprise Resource Planning
ESB	Enterprise Service Bus
ET	Eastern Time
ETL	Extract, Transformation and Loading
EV	Earned Value
FA	Fiscal Agent
FAR	Federal Acquisition Regulations
FFP	Federal Financial Participation
FMAP	Federal Medical Assistance Percentages
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
FTP	File Transfer Protocol
GPA	Government Procurement Agreement
HCA	Health Care Association

Acronym	Description
HCPCS	Healthcare Common Procedure Coding System
HCQF&P	RI EOHHS Division of Health Care Quality, Financing & Purchasing
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	US Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HP	Hewlett-Packard Development Company, LP
IBNR	Incurred But Not Reported
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IMD	Institution for Mental Disease
InRhodes	Rhode Island's eligibility system for Medicaid, SNAP, TANF, Child Care and general assistance
ISO	Insurance Services Office
IT	Informational Technology
IV&V	Independent Validation and Verification
JAD	Joint Application Design
KPI	Key Performance Indicators
LEA	Local Education Agencies
LOI	Letter of Intent
LPN	Licensed Practical Nurse
LTC	Long Term Care
MAGI	Modified Adjusted Gross Income
MAR	Management and Administration Reporting
MBE	Minority Business Enterprise
MDS	Minimum Data Set
MHRH	Department of Mental Health, Retardation and Hospitals (Now BHDDH)
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MOW	Meals on Wheels
MTBF	Mean Time Between Failures

Acronym	Description
MTTR	Mean Time to Repair
NCPDP	National Council for Prescription Drug Programs
NPI	National Provider Identifier
OCP	Open Core Protocol
OLAP	Online Analytical Processing
OMB	Office of Management and Budget
OMR	Office of Medical Review
PA	Prior Authorization
PACE	Program of All-Inclusive Care for the Elderly
PASSR	Preadmission Screening and Resident Review
PDF	Portable Document Format
PDL	Preferred Drug List
PERS	Personal Emergency Response System
PHI	Personal Health Information
PMI	Project Management Institute
PMO	Project Management Office
PMP	Project Management Plan
POS	Point of Sale
PROCATS	Legal transcription software
PV	Planned Value
R.I.G.L.	General Laws of the State of Rhode Island
REOMB	Recipient Explanation of Medical Benefits
RFP	Request for Proposal
RI	Rhode Island
RICHIST	Rhode Island Children's Information System
RIFANS	Rhode Island Financial System
RIPAE	Rhode Island Pharmaceutical Assistance Program
RIVIP	Rhode Island Vendor Information Program
RTM	Requirements Traceability Matrix
SACWIS	Statewide Automated Child Welfare Information System

Acronym	Description
SAN	Storage Area Network
SLA	Service Level Agreement
SMD	State Medicaid Director
SNAP	Supplemental Nutrition Assistance Program
SOA	Service-Oriented Architecture
SOW	Statement of Work
SPARC	Scalable Processor Architecture
SPI	Schedule Performance I
SS-A	State Self Assessment
SSN	Social Security Number
SUR	Surveillance and Utilization Review
SWICA	State Wage Information Collection Agency
SyRS	System Requirements Specification
TANF	Temporary Assistance for Needy Families
TPL	Third Party Liability
UAT	User Acceptance Testing
VPN	Virtual Private Network
WBS	Work Breakdown Structure
WINFACTS	Web-based Inmate Query System
WTO	World Trade Organization
XML	Extensible Markup Language

Appendix J: Service Level Agreements

1. Service Level Agreement – System Availability	
Key Performance Indicator	Retainage
System availability is to be defined as the percentage of possible uptime in a month that the MMIS environments (including all associated components) are available to users or to perform in a back-up capacity, including all weekends and holidays. Negotiated downtime for system maintenance during off-peak hours is not to be included in the calculation of system availability. Downtime. Downtime is to be defined as the term during which any functionality of the MMIS is not functioning/available due to hardware, operating system or application program failure. Outages approved by the State do not count towards downtime. System availability is to be based on the following hours of operation: MMIS Hours of Operation. MMIS access is to be available at a minimum 100% of the time during the State working hours, which are 8:00 a.m. to 5:00 p.m., Eastern Time, Monday through Friday, with access on the weekends and holidays as agreed upon by the State, and on an emergency basis if requested by the State. Other Components Hours of Operation. The State Website, the Consumer Direction Module (CDM) Website, the AskRhody Website and search engine and the Rite Resources Website, as well as the Pharmacy POS, Automated Prior Authorization system, and other system components, as required by the State, are to be available 100% of the time 24 hours per day, 7 days per week, except for agreed upon down time. The FA is to ensure system availability meets the following performance standards:	Up to 6% of the monthly operating fee, as follows: Any 1 of 6 not met: 1% Any 2 of 6 not met: 3% Any 3 of 6 not met: 5% 4 or more of 6 not met: 6%
1. Production Downtime POS. POS production downtime is to be 1% or less.	
2. All Other MMIS Components. Production downtime for all MMIS components except the POS is to be 1% or less.	

1. Service Level Agreement – System Availability	
3. Failover Downtime POS. POS failover downtime is to be 3% or less	
4. All Other MMIS Components. Failover downtime for all MMIS components except the POS is to be 1% or less.	
5. FA Network Connectivity Downtime. Contractor network connectivity downtime for all MMIS components, including POS, is to be 1% or less.	
6. Test Downtime Test downtime for all MMIS components, including POS, is to be 5% or less.	

2. Service Level Agreement – System Performance	
Key Performance Indicator	Retainage
System performance is to be defined as MMIS response time to user queries during the State working hours, which are 8:00 a.m. to 5:00 p.m., Eastern Time, Monday through Friday, with access on the weekends and holidays as agreed upon by the State, and on an emergency basis if requested by the State. The Consumer Direction Module (CDM) Website, the AskRhody Website and search engine and the Rite Resources Website, as well as the Pharmacy POS, Automated Prior Authorization system, and other system components' response times are to be measured 7 days a week, 24 hours a day, except during agreed upon downtime. The FA is expected to only be responsible for that portion of the system and communication link for which the FA has responsibility and control. For system response time performance measures, FA control is to be defined as any Subcontractor/Contractor service or point up to and including the State side of the router. The FA is to provide a system to monitor and report on response times as defined and approved by the State. All metrics are to be measured and evaluated in seconds.	Up to 6% of the monthly operating fee, as follows: Any 1 of 5 not met: 1% Any 2 of 5 not met: 3% Any 3 of 5 not met: 5% 4 or more of 5 not met: 6%

2. Service Level Agreement – System Performance	
The FA is to ensure system performance meets the following performance standards:	
1. Record Search and Retrieval Time. Within four (4) seconds 95% of the time, where record retrieval time is defined as the time elapsed after the retrieve command is entered until the record data loads to completion on the monitor.	
2. Screen Edit Time. Within two (2) seconds 95% of the time, where screen edit time is defined as 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.	
3. New Screen/Page Time. Within two (2) seconds 95% of the time, where new screen/page time is defined as the time elapsed from the time a new screen is requested until the data from the screen loads to completion on the monitor.	
4. Web Portal Response Time. Within four (4) seconds 99% of the time, where Web Portal response time is defined as the time elapsed from the command to view a response until the response appears or loads to completion on the monitor.	
5. POS On-Line Claims Response Time. Within 3 seconds 95% of the time, where POS on-line claims response time is to be measured as the time elapsed after the receipt of Provider on-line claim transaction until response notification is sent to Provider.	

3. Service Level Agreement – Database Updates	
Key Performance Indicator	Retainage
Database updates are to be defined as the activities necessary to maintain current and accurate data as required to conduct the functions outlined in this RFP, in compliance with all requirements herein. The FA is to ensure database update activities meet the following performance standards:	Up to 6% of the monthly operating fee, as follows: Any 1 of 11 not met: 1% Any 2 of 11 not met 3% Any 3 of 11 not met: 5%
1. Provider Database Electronic Updates Turnaround Time. Update Provider data received electronically	

3. Service Level Agreement – Database Updates	
within one (1) business day of receipt of file.	4 or more of 11 not met: 6%
2. Provider Database Error Correction Turnaround Time. Identify and correct errors within one (1) business day of error detection.	
3. Provider Licensure and Participation Requirements Updates Turnaround Time: On-Line Interfaces. Update the system with Provider licensing and participation requirements updates at least once a month for Providers licensed by Rhode Island licensing agencies with on-line interfaces.	
4. Provider Exclusion Updates Turnaround Time: On-Line Interfaces. Update the system with Provider exclusion updates at least once a month for Providers licensed by Rhode Island licensing agencies with on-line interfaces.	
5. Provider Licensure Updates Turnaround Time: Other. Update the system with Provider licensing/certification information for Providers licensed by agencies for which there is no on-line interface at least once a month.	
6. Member Eligibility Database Update Turnaround Time. The Member eligibility database update is to begin within two (2) hours of receipt of the updates and is to be complete prior to daily claims processing.	
7. Member Eligibility Update and Error Reporting Turnaround Time. Provide the State with update and error reports within 24 hours of receipt of the update.	
8. Member Eligibility Error Resolution Turnaround Time. Resolve eligibility transactions that fail the update process within two (2) business days of error detection.	
9. Pricing Files Updates Turnaround Time. Perform rate updates to pricing files within one (1) business day of the State approval	
10. Automated Prior Authorization System Criteria Updates Turnaround Time. Perform criteria updates within ten (10) business days of the State approval.	
11. Reference Files. Perform updates within five (5) business days of receipt.	

4. Service Level Agreement – Operational Problem Management

Key Performance Indicator	Retainage
The FA is to provide operational problem management to manage MMIS application problems as they occur during the Operations Phase of the project, including issues associated with all system components (the Consumer Direction Module (CDM) Website, the AskRhody Website and search engine and the Rite Resources Website, as well as the Pharmacy POS, Automated Prior Authorization system) at the State, the State- contracted Contractors (as specified by the State during DDI), and Fiscal Agent physical locations. Operational issues are to be classified, communicated to the State, documented, addressed and tracked per policies and procedure in the State Operational Problem Management Policy in the form provided by the State. The FA is to provide software tools to enable the tracking of a specific defect from identification through correction, including all testing performed to ensure the correct fix is in place. Issues are to be documented in the form of an Impact Statement Report. During the Operations Phase the FA is to categorize and resolve errors in accordance with Rhode Island problem management standards in the form provided by the State, as follows:	Up to 6% of the monthly operating fee, as follows: Priority 0 Errors standard not met: 3% Priority 1 Errors standard not met 1.25% Priority 2 Errors standard not met: 1.25% Priority 3 Errors standard not met: 0.50%
Priority 0 Errors. Critical business impact. Indicates MMIS is unavailable for use resulting in a critical impact on operations. Requires immediate State notification and resolution within two (2) hours.	
Priority 1 Errors. Serious business impact. Indicates serious production issues where the MMIS is usable but is severely limited and no workaround exists. Requires immediate State notification and resolution within 24 hours.	
Priority 2 Errors. Significant business impact. Indicates moderate production issue where MMIS is usable but a workaround is available (not critical to operations). Requires State notification within one (1) hour of problem discovery and resolution within 5 business days.	
Priority 3 Errors. Minimal business impact. Indicates the problem results in little impact on operations or a	

4. Service Level Agreement – Operational Problem Management

reasonable circumvention to the problem has been implemented. Requires the State notification within one (1) hour of problem discovery and resolution within an agreed-upon schedule between the Contractor and the State (as defined by the State).

5. Service Level Agreement – Customer Service Support

Key Performance Indicator	Retainage
The FA is to provide customer service support, where customers are defined as Providers, Members, the State, and other system users. The FA is to maintain sufficient staff and systems to manage, track and report on Customer Services via multiple channels, including telephone, AVRS, Web portal, e-mail, and mail. The FA is to provide an integrated contact management system to be used in tracking and managing Customer contacts from all channels, and can report on Customer contact metrics separately. Customer Service support is to be available 100% of the time during the State working hours, which are 8:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday, (as specified by the State), and on an emergency basis if requested by the State. The FA is to ensure customer service support meets the following performance standards:	
1. Average Speed of Answer. At least 90% of all calls are to be answered within 30 seconds, where “answer” means for each caller who elects to speak to a live representative. Answer 95% of routine calls within 45 seconds during normal working hours. Answer 99% of routine calls within 60 seconds during normal working hours.	1% of the monthly operating fee
2. Ring Busy Rate. No more than 5% of incoming calls are to ring busy. Further, the call center put in place with the enhancements required in this procurement must meet the following: Ensure that the weekly average	1% of the monthly operating fee

5. Service Level Agreement – Customer Service Support	
number of incoming calls that are blocked (calls receiving a busy signal) shall be no more than one percent.	
3. On Hold Time. On hold time is to be less than 2 minutes for at least 90% of all calls, where on hold time is defined as the time (in seconds) elapsed before response by a human operator to the caller's inquiry. The weekly average wait or hold time shall not exceed one-hundred twenty seconds.	1% of the monthly operating fee
4. Abandon Rate. The weekly average abandon rate shall be no more than five percent. A call will be considered abandoned after the first thirty seconds when a caller chooses to disconnect after the introductory message and prior to being connected to a staff member or voice mail.	1% of the monthly operating fee.
5. Provider Phone Inquiry Response Timeliness. Respond to 100% of verbal (telephone) Provider inquiries within (1) business day of receipt.	1% of the monthly operating fee
6. Provider Written Inquiry Response Timeliness. Respond to at least 90% of written Provider correspondence within (5) business days of receipt.	Up to 3% of the monthly operating fee, as follows: >85% to <90% response: 1% >80% to ≤85% response 2% ≤80% response 3%
7. Remittance Advice Web Posting Timeliness. Post 100% of Remittance Advice concerning paid and denied claims on Web Portal within one (1) business day of the completion of payment cycle.	1% of the monthly operating fee

6. Service Level Agreement – Claims Adjudication	
Key Performance Indicator	Retainage
An adjudicated claim is defined as a claim that requires no further adjudication or a claim suspended from adjudication processing due to error condition/s, including those errors resulting from issues outside of the	

6. Service Level Agreement – Claims Adjudication

Contractor's claims processing system. The calculation for claims adjudication metrics is to be based upon monthly claims volume within each measure, unless otherwise noted.

The FA is to ensure claims adjudication meets the following performance standards:

1. Clean Claims Adjudication Rate – Electronic Claims. Adjudicate 95% of all clean electronic claims for payment or denial within 2 working days of receipt, where clean claim is defined as a claim that is properly completed and contains all required data elements necessary for processing. Electronic claims are those claims submitted via the following channels: direct data entry (DDE), Web Portal, Pharmacy Point-of-Sale and electronic batches.	0.5% of the monthly operating fee
2. Clean Claims Adjudication Rate – Paper Claims. Adjudicate 95% of all clean paper claims for payment or denial within 5 working days of receipt, where clean claim is defined as above. Paper claims are those claims submitted in hard copy.	0.5% of the monthly operating fee
3. POS Claims Adjudication Rate. Adjudicate 100% of all Pharmacy Point-of-Sale claims for payment or denial within 3 seconds of receipt.	0.5% of the monthly operating fee
4. Suspended Claims Finalization Rate. Finalize 100% of all suspended claims and submit to Accounts Payable for payment processing within 15 days of receipt. Suspended (or "pending") claim is defined as a claim suspended from adjudication processing due to error condition/s, including those errors resulting from issues outside of the Contractor's claims processing system. A claim is not to be submitted for payment processing until all error conditions	0.5% of the monthly operating fee
5. POS Daily Time-Out Rate. Maintain a less than 100 claims/day time-out rate for Pharmacy Point-of-Sale 100% of the time.	1% of the monthly operating fee per daily occurrence

7. Service Level Agreement – Claims Payment	
Key Performance Indicator	Retainage
The FA is to be responsible for timely and accurate claims payment. The FA is to ensure claims payment meets the following performance standards:	
1. Payment Cycle Schedule. Run at least one (1) payment cycle biweekly based on release criteria entered by the State. Failure to meet the defined threshold one or more weeks in the defined month constitutes failure to achieve for the full month.	Up to 1% of the monthly operating fee, as follows: Any 1 of 2 not met: 0.5%
2. Notification of Overpayment. Provide the State written notification within 48 hours of discovery of any overpayments, duplicate payments, or incorrect payments (regardless of cause).	Any 2 of 2 not met: 1%

8. Service Level Agreement – Reporting	
Key Performance Indicator	Retainage
Reporting is to be defined as the processes, activities, and deliverables associated with regular reporting. The FA is to ensure reporting meets the following performance standards:	
1. Daily Reports Availability Schedule: accessible to users by 8:00 a.m. of the next State business day.	0.5% of the monthly operating fee
2. Weekly Reports Availability Schedule: accessible to users by 8:00 a.m. of the next State business day after the scheduled run.	
3. Monthly Reports Availability Schedule: accessible to users by 8:00 a.m. of the next State business day following the end of the month (as determined by the State).	
4. Quarterly Reports Availability Schedule: accessible to users by 8:00 a.m. of the next the State business day following the end of the quarter.	
5. Annual Reports Availability Schedule: accessible to users by 8:00 a.m. of the next the State business day following end of the year (Federal fiscal, State	

8. Service Level Agreement – Reporting	
fiscal, or other annual cycle).	
6. Federal and State Reporting and File Production/Distribution Schedule. Produce and submit all required Federal and state reports and data files on a schedule defined per regulation and by the State.	

9. Service Level Agreement – Drug Rebate	
Key Performance Indicator	Retainage
The FA is to define the processes, activities and deliverables necessary to support the administration of the State Drug Rebate program. The FA is to ensure the Drug Rebate program meets the following performance standards:	
1. Manufacturer Data Update Turnaround Time. Update the manufacturer rebate data within 24 hours of receipt of the update from CMS.	Up to 3% of the monthly operating fee, as follows: Any 1 of 8 not met: 0.5% Any 2 of 8 not met: 1% Any 3 of 8 not met: 2% Any 4 or more of 8 not met: 3%
2. Invoice Production Turnaround Time. Generate and mail invoices to manufacturers within sixty (60) days of the end of the quarter.	
3. Data Update Schedule: CMS Tape. Load the CMS tape quarterly.	
4. Data Update Schedule: Provider File. Update the Provider file weekly.	
5. Data Update Schedule: Claims File. Load the claim files monthly.	
6. Data Update Schedule: T-Bill Rate. Update the US T-Bill rate weekly.	
7. Data Update Schedule: System Update. Update the system nightly.	
8. Collection: Ensure that 97% of invoices eligible for Drug Rebate are identified for collection.	

10. Service Level Agreement – Operational Functionality	
Key Performance Indicator	Retainage

10. Service Level Agreement – Operational Functionality	
The operational functionality items require timely response from the FA with the consumer of the item. The FA is to ensure operational functionality meets the following performance standards:	
1. Prior Authorization. All requests for prior authorization must be completed with five (5) working days of the date of the request.	0.5% of the monthly operating fee
2. TPL/Trauma. All claims identified as possible trauma recoveries or as Third Party Liabilities must initiate recovery activity within three (3) days of identification.	0.5% of the monthly operating fee
3. Adjustments. All claims requiring an adjustment are treated as new claims and thus should undergo claims processing using the same standards as new claims.	0.5% of the monthly operating fee
4. SURS Reviews. The SURS reviews must take place quarterly and the results requiring action must be acted upon within thirty (30) days.	0.5% of the monthly operating fee
5. Financial Controls. Financial controls must be reconciled within one month.	0.5% of the monthly operating fee
6. Provider Enrollment. Process complete (clean) Provider applications, including entry of all Provider information, within (4) business days of receipt (regardless of media of application -- paper, electronic).	0.5% of the monthly operating fee

Appendix K: List of CNOM's

Agency	CNOM	Population / Service Description	Eligibility and MMIS Processing
EOHHS	Early Intervention (EI)	Youth at Risk for Medicaid : Coverage of detection and intervention services for at-risk young children not eligible for Medicaid.	Eligibility is determined outside of InRhodes. A "Shell" case is created in InRhodes and sent to MMIS. If client is known to InRhodes already, the MMIS Medical Assistance (MA) segment is not updated with EI eligibility. MMIS maintain EI-only segments. MMIS edits for age of the client (3 years old or less) on claims for "EI-Only" beneficiaries. MMIS not able to perform edit on EI services for MA clients.
DHS	GPA Medical	Non-working Disabled Adults : Non-working disabled adults ages 19-64 who do not qualify for disability benefits.	Eligibility currently maintained in InRhodes.
EOHHS	Community Health Centers	Payments to Federally Qualified Health Centers (FQHC's) for uninsured populations : Expenditures not to exceed on an annual basis \$2.4 million total computable (Federal & non-Federal)	Eligibility is currently determined manually. CNOM is not client-specific, only provider specific.
EOHHS	Adaptive Telephone Equipment	Adults with Disabilities at Risk for LTC : HCBS waiver-like services for adults with disabilities with incomes at or below 300% of SSI with income and resources lists above the Medicaid limits.	Not an active CNOM at this time.
EOHHS	Home Modification	Adults with Disabilities at Risk for LTC : HCBS waiver-like services for adults with disabilities with incomes at or below 300% of SSI with income and resources lists above the Medicaid limits.	Eligibility currently maintained in MMIS.

Agency	CNOM	Population / Service Description	Eligibility and MMIS Processing
EOHHS	Personal Care Attendant	Adults with Disabilities at Risk for LTC : HCBS waiver-like services for adults with disabilities with incomes at or below 300% of SSI with income and resources lists above the Medicaid limits.	Eligibility currently maintained in MMIS.
DHS	Social Services for the Blind	Adults with Disabilities at Risk for LTC : HCBS waiver-like services for adults with disabilities with incomes at or below 300% of SSI with income and resources lists above the Medicaid limits.	Eligibility currently maintained in MMIS.
DEA	Co-Pay Day Care	Elders 65 and over : At risk for long-term care (LTC) who are in need of home and community-based services.	Eligibility currently maintained in InRhodes.
DEA	Co-Pay Home Care	Elders 65 and over : At risk for long-term care (LTC) who are in need of home and community-based services.	Eligibility currently maintained in InRhodes.
DEA	Transportation (RIDE)	Elders 65 and over : At risk for long-term care (LTC) who are in need of home and community-based services.	Eligibility currently maintained in InRhodes.
DEA	Case Management	Elders 65 and over : At risk for long-term care (LTC) who are in need of home and community-based services.	Eligibility currently maintained in InRhodes.
BHDDH	MH Inpatient Non-Hospital Care	Uninsured Adults with Mental Illness : Services for uninsured adults with mental illness and or substance abuse problems not eligible for Medicaid	Eligibility currently maintained in MMIS.
BHDDH	MH Community Mental Health	Uninsured Adults with Mental Illness : Services for uninsured adults with mental illness and or substance abuse problems not eligible for Medicaid	Eligibility currently maintained in MMIS.
BHDDH	SA Detox Programs	Uninsured Adults with Mental Illness : Services for uninsured adults with mental illness and or substance abuse problems not eligible for Medicaid	Eligibility currently maintained in MMIS.
BHDDH	SA Community Programs	Uninsured Adults with Mental Illness : Services for uninsured adults with mental illness and or substance abuse problems not eligible for Medicaid	Eligibility currently maintained in MMIS.

Agency	CNOM	Population / Service Description	Eligibility and MMIS Processing
BHDDH	MH – CMAP	Uninsured Adults with Mental Illness : Services for uninsured adults with mental illness and or substance abuse problems not eligible for Medicaid	Eligibility currently maintained in MMIS.
BHDDH	DD Day & Supported Employment	Adults with Disabilities at Risk for LTC : HCBS waiver-like services for adults with disabilities with incomes at or below 300% of SSI with income and resources lists above the Medicaid limits.	Eligibility is currently determined manually.
DCYF	Residential Diversion CBH	Core & Preventive Services : Core and preventive services for Medicaid eligible at risk youth	Medicaid eligible in InRhodes. CNOM is for service (manual determination).
DCYF	Residential Diversion CW	Children with Special Health Care Needs : CSHCN who are 21 and under who would otherwise be placed in voluntary State custody.	Medicaid eligible in InRhodes. CNOM is for service (manual determination).
DCYF	Residential Diversion CNOM 9	Allows community-based services to extend to youth who are not Medicaid eligible once they leave a voluntary DCYF residential placement for up to six months. Services could also be used to avert a voluntary placement to DCYF residential services for youth who are not Medicaid eligible, but do not meet Katie Beckett criteria.	Medicaid eligible in InRhodes. CNOM is for service (manual determination).
DCYF	Reunification Support CNOM 8	Children receiving Substance Abuse and MH Services. Parents are DCYF and Rite Care MA eligible. The Rite Care premium is paid by the CNOM to keep family in Rite Care.	Medicaid Rite Care eligible in InRhodes. CNOM is for service (manual determination).
BHDDH	Substance Abuse Non-IMD Res.	Non-residential substance abuse program paid on a per diem per day rate. Case Management done by third party and audited by BHDDH.	Eligibility currently maintained in MMIS.
BHDDH	Methadone	Non-residential substance abuse program paid at a weekly rate. Requires screenings but no prior authorization.	Eligibility currently maintained in MMIS.
BHDDH	Substance Abuse Outpatient	Non-residential, outpatient substance abuse program	Eligibility currently maintained in MMIS.
DOH	AIDS Drug Assistance Program	HIV: Persons living with HIV who	Eligibility uploaded to

Agency	CNOM	Population / Service Description	Eligibility and MMIS Processing
		are not eligible for Medicaid	MMIS nightly through secure FTP.
DOH	Women's Cancer Screening	Payments to Federally Qualified Health Centers (FQHC's) for uninsured populations : Expenditures not to exceed on an annual basis \$2.4 million total computable (Federal & non-Federal)	Eligibility is not online. Claims are paid manually.

Appendix L: Contents of Bidders' Library

State of Rhode Island MMIS RFP Bidders' Library

To assist with vendors in responding to this request for proposal, the following documents have been collected and organized in a Bidders' Library. The following is an index of the information made available in the Bidders' Library with Document/Folder Title and a high level description.

Current MMIS Documentation:

Document Title	Description
1.0 MMIS and Fiscal Agent Services Overview	Provides high level overview of current MMIS system functions and system diagrams for MMIS Network and Web Portal. Appendices include Hardware and Software lists.
2.0 MMIS Subsystem Diagram	Technical process flow diagram of MMIS Subsystems.
3.0 MMIS Subsystem Documentation	Narrative descriptions of all Subsystems contained within the MMIS including subsystem flowcharts, screenshots, reports, and processes.
4.0 MMIS Screen User Documentation	Documentation includes screen shots; narrative for screen navigation; claims edit definitions; field definitions, lengths and types; field level edits, view, and query definitions for the following subsystems: 1. Claims 2. Cost Avoidance 3. DUR 4. Employer Insurance 5. EPSDT 6. Financial 7. Managed Care 8. PCS 9. Pharmacy 10. Prior Authorization 11. Provider 12. Recipient 13. Reference 14. TPL
5.0 MMIS Reports	List of all reports within the MMIS with a brief description of its contents and use.

Document Title	Description
6.0 External Interface List	Excel spreadsheet that lists all external interfaces.
7.0 MMIS Claims Edit Listing	Documentation is organized by Claims Edit number, and if edit is set by type of claim.
8.0 Provider Documentation	Provider Documentation includes the RI Companion Guide for Electronic Transactions as well as the current Provider Manual.
9.0 RI Developer Standards	Provides documents that discuss C, C++ coding standards, tips, and sample SQL concepts. Includes the following documents: 1.c_stds_addenum 2.C_TIPS 3.Coding Standards 4.Embedded SQL for RI 5.RI Technical Environment Overview
10.0 MMIS Source Code	Source Code for the RI MMIS will be made available to prospective bidders upon request.
11.0 Claims Resolution Manual	User manual for resolving claims edits
12.0 MMIS Data Dictionary	The MMIS Data Dictionary contains field level definitions, lengths, types.
13.0 MMIS Table Manual	Manual describes in detail the data tables used in the MMIS.
14.0 MMIS Table Info	Contains data table definitions including Column information type, field lengths, nulls, defaults, and sequencing.
15.0 MMIS Cycle Listing	Detailed technical execution scripts for each cycle action/sequence.
16.0 SFY Cycle Calendar	Calendar for SFY11 reflecting financial cycle activities.

Other Reference Materials:

Document Title	Description
17.0 RI Global Waiver	Approved Global Waiver documentation which

Document Title	Description
	details the RI Medicaid program.
18.0 RI State Plan	The current RI State Plan.
19.0 Data Warehouse Documentation	Overview of the Data Warehouse, structure, platform, interfaces, and data structure. This also includes documentation for the Encounter Claims data processing.
20.0 Physical Hosting Specifications	Diagram of MMIS system network topology and narrative description of MMIS system host platform, application, application development, and network architecture.
21.0 MITA State Self-Assessment	Provides high level overview of current MMIS system functions and system diagrams for MMIS Network and Web Portal. Appendices include Hardware and Software lists.
22.0 CMS Medicaid Enterprise Certification Toolkit	The Certification Checklists that define MMIS requirements that must be achieved for federal certification.
23.0 Overview of RI Eligibility Groups	Documentation summarizes mandatory and optional eligibility groups.
24.0 RI Dept. of Administration and DoIT Acceptance Use Policy	RI's information security policy.
25.0 RI Operations Metrics and Volumes	Provides operations volumes for claims, prior authorizations, managed care enrollments, call volume, and provider enrollments. Fiscal Agent Quarterly Performance reports are also included.
26.0 Additional Application Information	Provides information about additional ancillary applications associated with the RI MMIS.
27.0 Encounter Data Processing	Provides information about encounter data submissions to the RI MMIS from managed care programs.

Appendix M: Mandatory Proposal Submission Requirements Checklists

This section appendix includes the following checklists:

- M.1 Mandatory Technical Proposal Requirements Checklist
- M.2 Mandatory Cost Technical Proposal Requirements Checklist

M.1 Mandatory Technical Proposal Requirements Checklist

RFP Requirement	Acknowledgment	State Verification
GENERAL REQUIREMENTS PER SECTION 4.1.1		
Bidder is registered with the RI Department of Administration, Office of Purchases RI Bidder Information program (RIVIP).	☐	
Bidder has completed and forwarded a signed W-9 Request for Taxpayer Identification Number and Certification to: Office of Accounts &U Control, 1 Capitol Hill, 4th Floor, Providence, RI 02908, Attn: Pre-Audit Section.	☐	
Bidder submitted a Letter of Intent to Submit a Proposal as described in Section 2.7 by 1:00 p.m. E.T. on November 21, 2011.	☐	
Bidder had at least one representative at the mandatory Bidders' Conference on November 16, 2011 at 1:30 p.m. E.T.	☐	
PROPOSAL SUBMISSION REQUIREMENTS PER SECTIONS 4.1.2		
Proposal was received on time at DOA, Division of Purchasing by 3:00 p.m. E.T. on January 15, 2011.	☐	
Proposal is sealed and labeled on the outside of the package "SEALED BID" and shows the title, "Proposal for the Transition, Enhancement, Operation and Maintenance of the Medicaid Management Information System" and includes the proposal due date and the name of the Bidder.	☐	
Technical Proposals and Cost Proposals are sealed in separate envelopes or boxes within the "Sealed Bid." Each Proposal is clearly marked "Technical Proposal" or "Cost Proposal" and includes the title, proposal due date and name of the Bidder	☐	
PROPOSAL SUBMISSION REQUIREMENTS PER SECTIONS 4.2.3		

RFP Requirement	Acknowledgment	State Verification
Bidder submitted the Mandatory Technical Proposal Submission Requirements Checklist as Section 3 of the Technical Proposal. All copies are signed, and the copy with the original signature is included in the "Original Technical Proposal."	☐	
PROPOSAL SUBMISSION REQUIREMENTS PER SECTION 4.2		
Bidder submitted five (5) hard copies of the Technical Proposal, each in a three-ring binder, and ten (10) CD-ROM copies in Microsoft Office (Word, Excel and PowerPoint) 2003 format or Adobe Acrobat (PDF) format.	☐	
One hard copy of the Technical Proposal contains original signatures and is clearly marked as the "Original Technical Proposal."	☐	
Proposals are printed on 8½ X 11 inch paper (letter size) and double-sided. Proposals are single-spaced, and the text font is no smaller than 12 points.	☐	

RFP Requirement	Acknowledgment	State Verification
The Technical Proposal is submitted in the following order, and sections use the following section numbers: 1. RIVIP Bidder Certification Cover Form 2. Transmittal Letter 3. Mandatory Technical Proposal Requirements Checklist 4. Notices and Certifications 5. Executive Summary 6. Bidder Identification Information including Subcontractor Identification 7. Bidder Financial Information 8. Bidder Qualifications and Experience 9. Approach to Completing the Statement of Work 10. Approach to Project Staffing 11. Approach to Meeting Functional and Technical Requirements	☐	
Bidders' Technical Proposal contains no cost information.	☐	
SIGNED COVER SHEET PER RFP COVER PAGE PER SECTION 4.2.1		
A signed copy of the RIVIP Bidder Certification Cover Form is submitted as Section 1 of the Technical Proposal.	☐	
TRANSMITTAL LETTER PER SECTION 4.2.2		
Transmittal Letter is submitted as Section 2 on official business letterhead and contains the firm's name and address.	☐	
Transmittal Letter is signed in ink by the individual authorized to commit the Bidder to the proposed scope of work and clearly indicates the name and title.	☐	
• Transmittal Letter contains the following statements: • An unequivocal statement which	☐	

RFP Requirement	Acknowledgment	State Verification
acknowledges and agrees to all of the rights of the State of Rhode Island, including the procurement rules and procedures, terms and conditions, and all other rights and terms specified in this RFP • A statement of the Bidder's willingness to enter into an agreement with the State, which includes a reference to the terms and conditions presented Section 9 of this RFP • An affirmative statement agreeing to the payment and retainage terms stated in Section 9.2.20 of this RFP • The Bidder's Federal Tax Identification Number • Confirmation that the Bidder is licensed to do business in the State of Rhode Island • A statement that the person signing this proposal is authorized to make decisions as to the proposed work and that he or she has not participated, and will not participate, in any action contrary to the RFP • The name and telephone number of the Bidder's representative who may be contacted for all contractual matters • A statement that the proposal was developed without collusion with other eligible Bidders • A statement that the Bidder does not and will not have any interest that will conflict, in any manner or degree with the performance of services required under this RFP • The Bidder's assurance that the proposal will remain in full force and effect for at least 180 days from the proposal due date, which will be specified in the Transmittal Letter • A statement confirming that no cost information is included in the Technical Proposal • A statement from the Bidder verifying that the applicable software applications for this project meet the Department of Administration, Division of Information Technology, "Acceptable Use Policy" as documented in the Bidders' Library		

RFP Requirement	Acknowledgment	State Verification
- If the use of subcontractor(s) is proposed, a statement from the bidder that they will use the proposed subcontractors services and from each subcontractor shall be appended to the Transmittal Letter and signed by an individual authorized to legally bind the subcontractor stating: - The scope and percentage of work to be performed by the subcontractor (measured as a percentage of the total agreement price paid directly to the subcontractor) - The subcontractor's willingness to perform the work indicated - The subcontractor's intent to sign a formal agreement with the Bidder if the Bidder is awarded the Contract - A statement that neither the Bidder nor any proposed subcontractor has been found in default of previous contracts in the State of Rhode Island		
NOTICES AND CERTIFICATIONS PER RFP SECTION 4.2.4		
Bidders have included a signed copy of the following forms as Section 4 of the Technical Proposal.	☐	
- Independent Contractor Certification (Section 4.1). - Drug Free Work Place Policy Contractor Certificate of Compliance and Subcontractor Compliance (If applicable) (Section 4.2) - Certification Regarding Environmental Tobacco Smoke (Section 4.3) - Certification Regarding Debarment, Suspension, and Other Responsibility Matters Primary Covered Transactions (Section 4.4) - A signed W-9 Request for Taxpayer Identification Number and Certification (Section 4.5).	☐	

RFP Requirement	Acknowledgment	State Verification
EXECUTIVE SUMMARY PER RFP SECTION 4.2.5		
Technical Proposal includes an Executive Summary of not more than ten (10) pages as Section 5 of the Technical Proposal.	☐	
BIDDER IDENTIFICATION INFORMATION INCLUDING SUBCONTRACTOR IDENTIFICATION PER RFP SECTION 4.2.6		
Bidder includes the following identification information as Section 6 of the Technical Proposal: • Organization's full company or corporate name • Address of the organization's headquarters office • How the entity is organized (proprietorship, partnership, corporation) • Organization chart of the entity clearly depicting the Bidder's reporting relationship • Names and addresses of any parent organization, any partially or wholly owned subsidiaries, and any other related organizations • State in which the Bidder is incorporated • Address of the Bidder's office location responsible for performance under the resulting contract if awarded the Contract • Federal Tax Identification Number	☐	
Bidder has included the following for each subcontractor: • Subcontractor's name, address and telephone number • The subcontractor's intent to sign a formal agreement with the Bidder if the Bidder is awarded the Contract	☐	
BIDDER FINANCIAL INFORMATION PER RFP SECTION 4.2.7		

RFP Requirement	Acknowledgment	State Verification
Bidder has provided financial information about the stability and financial strength of the organization such as a current Dun and Bradstreet Report, an Annual Report containing a Compiled Income Statement and Balance Sheet verified by a CPA firm, or tax returns and financial statements including income statements and balance sheets for the most recent 3 years and any available credit reports.	☐	
This section includes company size, organization, date of incorporation, ownership, number of employees, revenues for the previous three (3) fiscal years.	☐	
Bidder has disclosed any and all judgments, pending or expected litigation, or other real potential financial reversals, which might materially affect the viability or stability of the Bidder's organization; or certified that no such condition is known to exist.	☐	
If the Bidder is either substantially or wholly owned by another corporate entity, the Bidder has included similar financial information for the parent organization and a statement that the parent will unconditionally guarantee performance by the Bidder in each and every term, covenant, and condition of such contract as may be executed by the parties.	☐	
Required financial information is provided for any proposed subcontractor whose percentage of work to be performed (measured as percentage of total contract price) equals or exceeds 20 percent.	☐	
BIDDER QUALIFICATIONS AND EXPERIENCE PER RFP SECTION 4.2.8		

RFP Requirement	Acknowledgment	State Verification
• The Technical Proposal includes Bidder Qualifications and Experience as Section 8 of the Technical Proposal, including the following sections: • Takeover and transition of an existing MMIS (Section 8.1) • Enhancement of an MMIS (Section 8.2) • Maintenance and Operations of an MMIS (Section 8.3) • Implementation and Operations of Multi-Tiered Architecture, including ESBs and Web-based systems (Section 8.4) • Hosting of a large-scale human services system such as MMIS, TANF, SNAP, SACWIS and Child Support (Section 8.5) • Hosting of other large-scale systems (Section 8.6) • Implementation of Care Management COTS or transfer applications (Section 8.7)	☐	
• Bidder's proposal includes a minimum of three (3) references, including client name, reference name, reference title, address, e-mail address and telephone number, that verify that the Bidder meets experience requirements	☐	
• Bidder shows relevant experience to verify it meets the minimum requirements in Section 2.3. • The Bidder must be or have been the prime FA (not a subcontractor) for successful operation and maintenance of a State's certified MMIS for at least one (1) year OR • The Bidder must have been the prime FA for the successful implementation of a State's MMIS, for which certification was obtained	☐	

RFP Requirement	Acknowledgment	State Verification
Bidder provides the following information in this section: • A list of prior and existing contracts or agreements that the Bidder has entered into with the State of Rhode Island • A list of any persons named in the proposal (prime or subcontractor personnel) who is or was an employee of the State of Rhode Island in the past 12 months, include the name, State agency, job title and separation date and the Contract responsibilities of the person proposed; or a statement that no such relationship exists. • A description of any contract termination for the Bidder or any proposed subcontractor during the past three (3) years for convenience, nonperformance, non-allocation of funds, or any other reason, or a statement that no such terminations have occurred.	<input data-bbox="1057 365 1084 394" type="checkbox"/>	

APPROACH TO COMPLETING THE STATEMENT OF WORK PER RFP SECTION 4.2.9		
Bidder includes the following sections as Section 9 of the Technical Proposal: • Approach to Project Initiation and Kick-Off Activities (Section 9.1) • Approach to Project Management (Section 9.2) • Approach to the Transition Activities (Section 9.3) • Approach to Maintenance and Operations (Section 9.4) • Approach to the Enhancement Activities (Section 9.5) • Approach to the Certification Activities (Section 9.6) • Approach to the Turnover Activities (Section 9.7)	☐	

APPROACH TO PROJECT STAFFING PER RFP SECTION 4.2.10		
• Bidder includes the following sections as Section 10 of the Technical Proposal: • Approach to Staffing for Transition Activities (Section 10.1) • Approach to Staffing for Maintenance and Operations (Section 10.2) • Approach to Staffing for Enhancement Activities (Section 10.3) • Project Organization Charts and Position Descriptions (Section 10.4) • Resumes of Key Personnel (Section 10.5)	☐	
APPROACH TO MEETING FUNCTIONAL AND TECHNICAL REQUIREMENTS PER RFP SECTION 4.2.11		
Bidder includes the following sections as Section 11 of the Technical Proposal: • Approach to Meeting Requirements for Functional Enhancements (Section 11.1) • Approach to Meeting Requirements for Technical Enhancements (Section 11.2) • Approach to Meeting Current MMIS Functional and Technical Requirements (Section 11.3)	☐	

• Bidder includes the following checklists (completed and signed): • Requirements Checklist for Care Management, Requirements Supporting Cost Savings Initiatives and Customer Service (Appendix O.1) • Requirements Checklist for Claims Processing Requirements, Eligibility (Beneficiary Management Requirements), Managed Care Requirements, and Financial and Program Management (Appendix O.2) • Requirements Checklist for Technical Enhancements (Appendix O.3) • Checklist for Acknowledgment of Business Objectives for Enhancements (Appendix O.4) • Checklist for Acknowledgment of Current MITA Business Processes (Appendix O.5) • Checklist for Transition of Current Technical Capabilities (Appendix O.6) • Checklist for Current Fiscal Agent Responsibilities (Appendix O.7)	☐	
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M.2 Mandatory Cost Proposal Requirements Checklist

RFP Requirement	Acknowledgment	State Verification
COST PROPOSAL SUBMISSION REQUIREMENTS PER SECTION 4.3		
Cost Proposals are sealed in separate envelopes or boxes within the "Sealed Bid." Each Proposal is clearly marked "Cost Proposal."	☐	
Bidder submitted the Mandatory Cost Proposal Submission Requirements Checklist as Section 2 of the Technical Proposal. All copies are signed as originals.	☐	
Bidder submitted five (5) hard copies of the Cost Proposal and five (5) electronic copies on CD-ROM in Microsoft Office 2003 format or Adobe Acrobat (PDF) format.	☐	
Each hard copy of the Cost Proposal contains original signatures. Cost Proposals are clearly marked as the "Original Cost Proposal #1 through Original Cost Proposal #5).	☐	
Proposals are printed on 8½ X 11 inch paper (letter size) and double-sided. Proposals are single-spaced, and the text font is no smaller than 12 points.	☐	
The Cost Proposal is submitted in the following order, and sections use the following section numbers: 1. Executive Summary 2. Mandatory Cost Proposal Requirements Checklist 3. Pricing Schedule for the Total Project 4. Pricing Schedule for Enhancement Activities 5. Pricing Schedules for Maintenance and Operations Activities	☐	
Cost Proposal includes an Executive Summary of not more than three (3) pages as Section 1 of the Technical Proposal.	☐	

RFP Requirement	Acknowledgment	State Verification
Section 3 of the Cost Proposal includes a Pricing Schedule for the Total Project (Pricing Schedule A), which is signed in ink by the individual authorized to commit the Bidder.	☐	
Section 4 of the Cost Proposal includes Pricing Schedule for Enhancement Activities (Pricing Schedule B), which is signed in ink by the individual authorized to commit the Bidder.	☐	
Pricing Schedule B contains a firm, fixed price for each of the nine (9) enhancements.	☐	
Section 5 of the Cost Proposal includes Pricing Schedules for Maintenance and Operations for the five (5) base contract years (Pricing Schedules C.1 through C.5), which are signed in ink by the individual authorized to commit the Bidder.	☐	
Each of Pricing Schedules C.1 through C.5 contains a Total MMIS System Cost, a Modification Cost and Total Evaluated Cost.	☐	

Signature	Title	Date
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Appendix N: Cost Proposal Schedules

This appendix includes the following Pricing Schedules:

- Pricing Schedule A. Pricing Schedule for MMIS Takeover, Enhancement, Operations and Maintenance - Total Evaluated Proposal Price
- Pricing Schedule B. Pricing Schedule for MMIS Takeover, Enhancement, Operations and Maintenance - Enhancement Activities
- Pricing Schedule C.1. Pricing Schedule for MMIS Takeover, Enhancement, Operations and Maintenance - Maintenance and Operations – Year 1
- Pricing Schedule C.2. Pricing Schedule for MMIS Takeover, Enhancement, Operations and Maintenance - Maintenance and Operations – Year 2
- Pricing Schedule C.3. Pricing Schedule for MMIS Takeover, Enhancement, Operations and Maintenance - Maintenance and Operations – Year 3
- Pricing Schedule C.4. Pricing Schedule for MMIS Takeover, Enhancement, Operations and Maintenance - Maintenance and Operations – Year 4
- Pricing Schedule C.5. Pricing Schedule for MMIS Takeover, Enhancement, Operations and Maintenance - Maintenance and Operations – Year 5

Pricing Schedule for MMIS Takeover, Enhancement, Operations, and Maintenance

Total Evaluated Proposal Price

Pricing Schedule A

<i>Total Evaluated Proposal Price</i>	
Total Evaluated Price for Enhancement Activities <i>(From Pricing Schedule B)</i>	\$
Total Evaluated Price for Maintenance and Operations <u>Year 1:</u> <i>(From Pricing Schedule C.1)</i>	\$
Total Evaluated Price for Maintenance and Operations <u>Year 2:</u> <i>(From Pricing Schedule C.2)</i>	\$
Total Evaluated Price for Maintenance and Operations <u>Year 3:</u> <i>(From Pricing Schedule C.3)</i>	\$
Total Evaluated Price for Maintenance and Operations <u>Year 4:</u> <i>(From Pricing Schedule C.4)</i>	\$
Total Evaluated Price for Maintenance and Operations <u>Year 5:</u> <i>(From Pricing Schedule C.5)</i>	\$
Total Evaluated Price for Contract:	\$

Signature

Title

Date

Pricing Schedule for MMIS Transition, Enhancement, Operations, and Maintenance

Enhancement Activities

Pricing Schedule B

Enhancement	Personnel / Labor	Facilities	Equipment	Network Communications	Testing	Training	Data Conversion & Implementation	Other Costs , including Travel	Total Fixed Price
Enhancement 1: Care Management									
Enhancement 2: Enhancements Supporting Cost Savings Initiatives									
Enhancement 3: Customer Service									
Enhancement 4: Claims Processing									
Enhancement 5: Eligibility (Beneficiary Management)									
Enhancement 6: Managed Care									

Enhancement 7: Financial and Program Management									
Enhancement 8: Web Foundation									
Enhancement 9: Enterprise Service Bus									

TOTAL FOR ENHANCEMENT ACTIVITIES \$_____

Signature

Title

Date

Pricing Schedule for MMIS Takeover, Enhancement, Operations, and Maintenance

Maintenance and Operations – Year 1

Pricing Schedule C.1

The price for Maintenance and Operations includes all MMIS basic operational services and transaction processing services as defined in Section 4.3.5.

<i>MMIS System Price</i>	
MMIS Operations Price	
Core MMIS	\$
Pharmacy Point-of-Sale	\$
Pharmacy Rebate	\$
Clinical Claims Review	\$
EOHHS Data Warehouse	\$
Provider Web Portal	\$
Claims Processing Support Services	
Provider Call Center	\$
Provider Enrollment	\$
Provider Training & Outreach	\$
ID Card Processing	\$
Premium Billing & Expenses	\$
Prior Authorizations	\$
Utilization Management	\$
Transaction Processing Cost	
Estimated 11,000 transactions at \$0.____ per transaction	\$
“Other Costs”	
Travel	\$
Other (add additional lines if necessary)	\$

Total	\$
-------	----

Modification Price		
Estimated number of modification hours for Evaluation purposes	All inclusive blended cost per hour	Total
20,000	\$	\$

Total Evaluated Price for Year 1	
MMIS System Price	\$
Modification Price	\$
Total Evaluated Price for Year 1	\$

Signature	Title	Date
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Pricing Schedule for MMIS Takeover, Enhancement, Operations, and Maintenance

Maintenance and Operations – Year 2

Pricing Schedule C.2

The price for Maintenance and Operations includes all MMIS basic operational services and transaction processing services as defined in Section 4.3.5.

<i>MMIS System Price</i>	
MMIS Operations Price	
Core MMIS	\$
Pharmacy Point-of-Sale	\$
Pharmacy Rebate	\$
Clinical Claims Review	\$
EOHHS Data Warehouse	\$
Provider Web Portal	\$
Claims Processing Support Services	
Provider Call Center	\$
Provider Enrollment	\$
Provider Training & Outreach	\$
ID Card Processing	\$
Premium Billing & Expenses	\$
Prior Authorizations	\$
Utilization Management	\$
Transaction Processing Cost	
Estimated 11,000 transactions at \$0.____ per transaction	\$
“Other Costs”	
Travel	\$

Other (add additional lines if necessary)	\$
Total	\$

Modification Price			
Estimated modification Evaluation purposes	number of hours for	All inclusive blended cost per hour	Total
20,000		\$	\$

Total Evaluated Price for Year 2	
MMIS System Price	\$
Modification Price	\$
Total Evaluated Price for Year 2	\$

Signature	Title	Date
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Pricing Schedule for MMIS Takeover, Enhancement, Operations, and Maintenance

Maintenance and Operations – Year 3

Pricing Schedule C.3

The price for Maintenance and Operations includes all MMIS basic operational services and transaction processing services as defined in Section 4.3.5.

MMIS System Price	
MMIS Operations Price	
Core MMIS	\$
Pharmacy Point-of-Sale	\$
Pharmacy Rebate	\$
Clinical Claims Review	\$
EOHHS Data Warehouse	\$
Provider Web Portal	\$
Claims Processing Support Services	
Provider Call Center	\$
Provider Enrollment	\$
Provider Training & Outreach	\$
ID Card Processing	\$
Premium Billing & Expenses	\$
Prior Authorizations	\$
Utilization Management	\$
Transaction Processing Cost	
Estimated 11,000 transactions at \$0.____ per transaction	\$
“Other Costs”	
Travel	\$
Other (add additional lines if necessary)	\$

Total	\$
-------	----

Modification Price		
Estimated number of modification hours for Evaluation purposes	All inclusive blended cost per hour	Total
20,000	\$	\$

Total Evaluated Price for Year 3	
MMIS System Price	\$
Modification Price	\$
Total Evaluated Price for Year 3	\$

Signature	Title	Date
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Pricing Schedule for MMIS Takeover, Enhancement, Operations, and Maintenance

Maintenance and Operations – Year 4

Pricing Schedule C.4

The price for Maintenance and Operations includes all MMIS basic operational services and transaction processing services as defined in Section 4.3.5.

<i>MMIS System Price</i>	
MMIS Operations Price	
Core MMIS	\$
Pharmacy Point-of-Sale	\$
Pharmacy Rebate	\$
Clinical Claims Review	\$
EOHHS Data Warehouse	\$
Provider Web Portal	\$
Claims Processing Support Services	
Provider Call Center	\$
Provider Enrollment	\$
Provider Training & Outreach	\$
ID Card Processing	\$
Premium Billing & Expenses	\$
Prior Authorizations	\$
Utilization Management	\$
Transaction Processing Cost	
Estimated 11,000 transactions at \$0.____ per transaction	\$
“Other Costs”	
Travel	\$
Other (add additional lines if necessary)	\$

Total	\$
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Modification Price		
Estimated number of modification hours for Evaluation purposes	All inclusive blended cost per hour	Total
20,000	\$	\$

Total Evaluated Price for Year 4	
MMIS System Price	\$
Modification Price	\$
Total Evaluated Price for Year 4	\$

Signature	Title	Date
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Pricing Schedule for MMIS Takeover, Enhancement, Operations, and Maintenance

Maintenance and Operations – Year 5

Pricing Schedule C.5

The price for Maintenance and Operations includes all MMIS basic operational services and transaction processing services as defined in Section 4.3.5.

<i>MMIS System Price</i>	
MMIS Operations Price	
Core MMIS	\$
Pharmacy Point-of-Sale	\$
Pharmacy Rebate	\$
Clinical Claims Review	\$
EOHHS Data Warehouse	\$
Provider Web Portal	\$
Claims Processing Support Services	
Provider Call Center	\$
Provider Enrollment	\$
Provider Training & Outreach	\$
ID Card Processing	\$
Premium Billing & Expenses	\$
Prior Authorizations	\$
Utilization Management	\$
Transaction Processing Cost	
Estimated 11,000 transactions at \$0.____ per transaction	\$
“Other Costs”	
Travel	\$
Other (add additional lines if necessary)	\$

Total	\$
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Modification Price		
Estimated number of modification hours for Evaluation purposes	All inclusive blended cost per hour	Total
20,000	\$	\$

Total Evaluated Price for Year 5	
MMIS System Price	\$
Modification Price	\$
Total Evaluated Price for Year 5	\$

Signature	Title	Date
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Appendix O: Bidder Acknowledgment Checklist

This appendix includes the following checklists:

- O.1 Requirements Checklist for Care Management, Requirements Supporting Cost Savings Initiatives and Customer Service Requirements
- O.2 Requirements Checklist for Claims Processing Requirements, Eligibility (Beneficiary Management Requirements), Managed Care Requirements, and Financial and Program Management Requirements
- O.3 Requirements Checklist for Technical Enhancements
- O.4 Requirements Checklist for Business Objectives for Enhancements
- O.5 Requirements Checklist for Current MITA Business Processes
- O.6 Requirements Checklist for Transition of Current MMIS Technical Capabilities
- O.7 Requirements Checklist for Fiscal Agent Responsibilities

O.1 Requirements Checklist for Care Management, Requirements Supporting Cost Savings Initiatives and Customer Service Requirements

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
Inputs					
CM.1.	Claims history of member services (paid, denied and pended), including claims for specific procedures, National Drug Codes (NDCs) and diagnoses as defined by DHS	☐	N/A		
CM.2.	Provider, member and reference data related to member's claim history	☐			
CM.3.	Electronic prior authorizations from the MMIS or EOHHS Data Warehouse	☐			
CM.4.	Electronic Preadmission Screening and Resident Review (PASRR) results from Qualidigm	☐			
CM.5.	Data entry of clinical information by case workers	☐			
CM.6.	Claims pended for medical review	☐			
CM.7.	Referrals for determination of medical necessity	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.8.	Provide the ability to electronically accept and track forms submitted by providers	☐			
CM.9.	Other inputs including internal and external e-mails, faxes, telephone calls, letters and online referrals or inquiries	☐			
Processing					
CM.10.	The Care Management System must be deployed on the Web Foundation. (See Technical Requirements, Section 7)	☐	N/A		
CM.11.	The Care Management System must be integrated with the other applications through the ESB. (See Technical Requirements, Section 7)	☐			
Care and Case Management Data Maintenance					

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.12.	Provide and maintain online Case and Care Management information for DHS and other agency Care Management programs, including, but not limited to DHS programs, such as: Home and Community Care Preventive and Medically Complex Cases (DHS)	☐			
CM.13.	Community and Assisted Living Waivers	☐			
CM.14.	Nursing Home Transition Services	☐			
CM.15.	Personal Choice Waiver	☐			
CM.16.	Habilitation Waiver	☐			
CM.17.	Shared Living Waiver	☐			
CM.18.	Children's Respite Waiver programs	☐			
CM.19.	PACE	☐			
CM.20.	ConnectCare Choice/Diversion	☐			
CM.21.	SSI-Enhanced Assisted Living	☐			
CM.22.	Social Services for the Blind	☐			
CM.23.	Early Intervention	☐			
CM.24.	Children in fee for service programs	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.25.	Katie Beckett	☐			
CM.26.	High-Cost cases	☐			
CM.27.	Other programs included in the Global Waiver demonstration	☐			
CM.28.	BHDDH case management programs, such as: CMAP	☐			
CM.29.	Methadone	☐			
CM.30.	Various Substance Abuse programs	☐			
CM.31.	Various MR and DD programs	☐			
CM.32.	DD Day and Supported Employment	☐			
CM.33.	Community Mental Health	☐			
CM.34.	Inpatient Non-Hospital (IMD) care programs	☐			
CM.35.	Though now operated and maintained by an ASP vendor, review and make recommendations for the future operation of DHS's DEA case management programs, such as: Co-Pay Day Care	☐			
CM.36.	Co-Pay Home Care programs	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.37.	Assisted Living	☐			
CM.38.	Nursing Home Transition	☐			
CM.39.	DCYF case management programs, such as: Various Residential Diversion programs	☐			
CM.40.	Reunification Support programs	☐			
CM.41.	DOH case management programs, such as Aids Drug Assistance Program and CNOM	☐			
CM.42.	Breast and Cervical Cancer (BCCTP) treatment and screening programs	☐			
CM.43.	Provide the capability to link all members of a household, as defined by DHS, and to easily identify all members of a household, whether currently eligible or not	☐			
CM.44.	Provide the capability to query by: All programs' member IDs	☐			
CM.45.	Provider ID (NPI)	☐			
CM.46.	Member name	☐			
CM.47.	Provider name	☐			
CM.48.	Member SSN (may need to be restricted by role)	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.49.	Disease/condition	☐			
CM.50.	Date of birth	☐			
CM.51.	Provide the ability to maintain, for each Care Management Plan, the following: Eligibility periods	☐			
CM.52.	Notification dates and responses	☐			
CM.53.	Assessment or screening schedules, dates and results	☐			
CM.54.	Case managers and primary care providers	☐			
CM.55.	Assessment or screening providers	☐			
CM.56.	Procedure codes and modifiers	☐			
CM.57.	Places of service	☐			
CM.58.	Dates of service	☐			
CM.59.	Referred services and providers	☐			
CM.60.	Treatment objectives and goals, including detailed care plans	☐			
CM.61.	Treatment status for conditions identified for follow-up	☐			
CM.62.	Dates of member and provider notices and responses	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.63.	Other data specified by DHS during the design sessions	☐			
CM.64.	Maintain case information to be used for other MMIS and EOHHS Data Warehouse processes, including claims adjudication, managed care, third party liability and mailings	☐			
CM.65.	Provide the ability for online updates and inquiries to care management data with assessment and screening results and dates, and referral and treatment dates for all conditions with access by SSN or member IDs	☐			
CM.66.	Provide the ability to add custom fields, all of which are reportable. Customized fields should include ability to populate lists such as: Dropdown lists (tables) that can be loaded with available resources (as defined by the State), e.g., transportation contacts, etc.	☐			
CM.67.	Dropdown lists (tables) that provide special program information	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.68.	Provide the ability to track payments for each member in total, and to limit payments to any combination of benefit plans based on total services or an overall dollar ceiling, as determined by the State. (e.g., Katie Beckett)	☐			
CM.69.	Provide the ability to flag members by: High-cost thresholds by dollar amount	☐			
CM.70.	Chronic illness	☐			
CM.71.	Member's benefits package (program indicator and eligibility category)	☐			
CM.72.	Provide the ability to flag members and providers for any ongoing reviews of the member or provider	☐			
CM.73.	Provide the ability to flag members who receive or are recommended to receive restricted services for specified period of time and indicate start and end dates	☐			
CM.74.	Provide the ability to automate staff assignments and track progress and timing of all staff assignments	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.75.	Provide a workflow process that maintains scheduled activities and generates tickler items as defined by DHS in design sessions	☐			
CM.76.	Provide the ability to identify members referred for case management, those under case management, and those released from case management. Identify the care coordinator for each member.	☐			
CM.77.	Provide access to the status of related limitations for which the member has had services, such as the number of office visits paid per month	☐			
CM.78.	Provide patient and case-level alerts to caution care managers to specific conditions (e.g., disease management programs, quality reviews, litigation, coordination of benefits, language barriers, etc.)	☐			
CM.79.	Maintain data at the member and household level that spans all care for each member and permits case managers to share member information such as: Clinical findings and history	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.80.	Psychosocial history	☐			
CM.81.	Laboratory	☐			
CM.82.	Pharmacy	☐			
CM.83.	Other information within defined parameters	☐			
Correspondence					
CM.84.	Automatically generate notices and letters according to DHS criteria	☐			
CM.85.	Provide the ability to include free-form text into template letters	☐			
CM.86.	Provide the ability to send service reminder notices to providers or members	☐			
CM.87.	Provide the ability to accept online updates of notification responses, assessment/screening information, and status	☐			
CM.88.	Provide the ability to track member correspondence	☐			
Medical Reviews					
CM.89.	Provide the customization ability to add letters and notices without custom programming via an administrative module	☐			
CM.90.	Provide for unique identification of medical review cases	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.91.	Provide the ability to set automated clinical, medical and administrative review criteria, such as electronic prior authorization requests and approvals	☐			
CM.92.	Provide the ability to access clinical criteria and guidelines. Allows the user to enter and modify business and clinical rules through a user interface that offers control over criteria/guidelines without requiring developer intervention, such as: Age	☐			
CM.93.	Gender	☐			
CM.94.	Provider	☐			
CM.95.	Treatment setting	☐			
CM.96.	Diagnosis(es)	☐			
CM.97.	Procedure/service	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.98.	Support the medical assessment process through a customizable electronic application to collect and document medical functional and clinical assessments by case workers and clinical staff. The core medical assessment questionnaire should have the flexibility to be customized by agency to meet specific program needs without the need of custom programming. It must be configurable to meet the needs of both medical and behavioral health programs	☐			
CM.99.	Provide the ability to maintain a standardized library of customized assessment fields that can be shared by assessments of other programs, to allow easier integration with other Data Warehouse assessment data.	☐			
CM.100.	Provide for the creation of custom reports by program from the detailed assessment data.	☐			
CM.101.	Provide for online templates for medical decisions and requests for additional information to members, providers and referring parties	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.102.	Provide the capability to assign acuity criteria	☐			
CM.103.	Provide concurrent review capabilities	☐			
Authorization of Services					
CM.104.	Allow authorization of services based on approval of care plans, assessments or other services by authorized users	☐			
CM.105.	Allow online update of the scope of services authorized, extend or limit the effective dates of authorization, and provide updates to the MMIS for adjustment or replacement of current prior authorizations	☐			
CM.106.	Provide authorized users with access to all member claims and encounter history relative to the services considered for prior authorization	☐			
CM.107.	Provide the ability for the Care Management System to bypass or automate prior authorization requests for State-defined diagnosis-to-procedure combinations	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.108.	Provide the ability to identify that services have been “authorized” and the ability to forward the decision to related parties (e.g., the referring person, the member, and the provider)	☐			
CM.109.	Provide reporting to identify authorized services per the previous requirement	☐			
CM.110.	Provide a mechanism to authorize and track traditional and non-traditional medical supplies and services purchased by the member enrolled in the self-directed waivers	☐			
Outputs					
CM.111.	Provide care management data to the EOHHS Data Warehouse on a schedule designated by DHS	☐			
CM.112.	Generate letters, correspondence and other materials to support care management activities, via an administrative module without the need for custom programming	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.113.	Generate prior authorizations to support the claims processing of services approved in member care plans. Automatically transmit PAs to MMIS via interface in standard HIPAA format.	☐			
CM.114.	Generate adjustments to prior authorizations based on modification of care plans by authorized users and transmit PA adjustments to the MMIS	☐			
CM.115.	Make the following types of reports available. Additional standard reports will be defined by DHS during the design sessions. Reports that support all federal and State reporting requirements	☐			
CM.116.	Medical review reports	☐			
CM.117.	Members under care management (open and closed cases)	☐			
CM.118.	Cost-saving reports	☐			
CM.119.	Staff assignment and status tracking reports	☐			
CM.120.	Activity list reports	☐			
CM.121.	HEDIS type reporting	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.122.	Provide reports that support outcome and compliance tracking such as: Prevention of specified diseases or conditions	☐			
CM.123.	Reporting by specified diagnoses or groups of diagnoses	☐			
CM.124.	Treatment services based on age groups	☐			
CM.125.	Patient satisfaction data	☐			
CM.126.	Mortality data	☐			
CM.127.	Provide the capability to analyze care being depicted as an episode of care, a global view of a beneficiary's treatment over time across all settings	☐			
CM.128.	Provide the ability to report by level of benefits or population such as TANF, SSI, SCHIP enrollees, by uninsured and by age grouping, children, adolescents, adults, or elderly	☐			
CM.129.	Provide reporting on quality improvement initiatives including but not limited to: Intensive benefits management	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.130.	Pain management	☐			
CM.131.	Prior authorization for high cost programs	☐			
CM.132.	Nursing Home Transition Program	☐			
CM.133.	Nursing Home Length of Stay	☐			
CM.134.	Foster Care Length of Stay	☐			
CM.135.	Preventative Care Program	☐			
CM.136.	Health Outcomes	☐			
CM.137.	Provide the functionality for ad-hoc reporting, data analysis, graphical data presentation, resulting in standard and parameter-driven reports	☐			
Interfaces					
CM.138.	Provide an automated interface with the MMIS to ensure timely and complete transmittal of member information, care plans and prior authorizations in standard HIPAA format	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.139.	Provide for an interface with the EOHHS Data Warehouse for information from other agencies, DOH information (such as data of death and immunization information) and encounter data	☐			
CM.140.	Provide a Web-enabled capability for the case record function to allow for authorized read and update access by contracted staff	☐			
CM.141.	Provide a Web-enabled capability for the case record function to allow for authorized read and update access by authorized contracted staff	☐			
CM.142.	Provide the ability to forward information via secure e-mail or the MMIS provider Web portal	☐			
Fiscal Agent Responsibilities					
CM.143.	Implement, maintain and operate the Care Management solution as defined by DHS during the design sessions	☐	N/A		
CM.144.	Scan, image and index all paper documentation and correspondence received and generated to support case management	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.145.	Customize medical assessment applications to support the needs of State agencies, including DHS, DOH, BHDDH, and DCYF	☐			
CM.146.	Provide technical and training support for the Care Management solution, as specified by DHS during the design sessions	☐			
CM.147.	Incorporate audit trails to allow information on source documents to be traced throughout the processing stages. Maintain audit trails for five years.	☐			
CM.148.	Maintain user-friendly systems navigation technology and a graphical user interface that allows users to move freely throughout the system using pull-down menus, the ability to open and view multiple screens concurrently, and point-and-click navigation without identifying data multiple times.	☐			
CM.149.	Provide security at a field, record and user level. Limit access to medically sensitive information contained in a case through levels of security	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CM.150.	Provide additional security levels for read and update at the field, record and user level for providers and contractors as authorized by EOHHS	☐			
CM.151.	Provide for context-sensitive help on screens for easy, point-and-click access to valid values and codes definitions by screen field	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
Inputs					
TPL.1.	Trauma indicators on claims, which generate SWICA (State Wage Information Collection Agency) and questionnaires, and open a Casualty Recovery case in the Case Tracking tool	☐			

ID	EOHHS Requirement		Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TPL.2.	Scanned responses to SWICA and questionnaires received from clients. Update MMIS TPL and Casualty Recovery Case Tracking information based on data received and scanned.		☐			
TPL.3.	Online updates to the tool by authorized users		☐			
TPL.4.	Data matches from other government programs, private insurance carriers and other State-specified sources identified by DHS in the design sessions		☐			
TPL.5.	Health coverage data including retroactive changes and State information from the State eligibility system, InRhodes		☐			
Processing						
TPL.6.	The FA will implement functionality and interfaces to support enhanced identification of TPL, improved cost recovery and assignment of cost recoveries. It will implement and maintain an application to track Casualty and Estate Recovery cases.		☐			
TPL.7.	The Case Tracking System must be deployed on the Web Foundation. (See Technical Requirements, Section 7)		☐	N/A		

ID	EOHHS Requirement		Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TPL.8.	The Case Tracking System must be integrated with the other applications through the ESB. (See Technical Requirements, Section 7)		☐			
Third Party Liability and Cost Recovery						
TPL.9.	Implement functionality to apply cost recoveries at the individual claim-level, as a single adjustment or mass adjustment		☐			
TPL.10.	Automatically process Medicare Part A, B, and C crossover claims and adjustments		☐			
TPL.11.	Generate a claims adjustment file for mass adjustment of claims when a case is settled		☐			
TPL.12.	Provide an automated multi-use Case Tracking tool allowing online access by specified users with the following functionality: Support workflow processes that create cases, trigger alerts, and allow for pending of work tasks		☐			
TPL.13.	Assign work items, cases and claims to staff by role and to staff by team		☐			

ID	EOHHS Requirement		Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TPL.14.	Store and retrieve relevant case data		☐			
TPL.15.	Provide a case notes feature that allows for documentation of case status, tracking of phone calls and correspondence		☐			
TPL.16.	Provide the ability to import claims history reports from the EOHHS Data Warehouse, based on case parameters such as member IDs, provider IDs, date spans, groups of procedures and diagnoses, as specified by DHS during the design sessions		☐			
TPL.17.	Provide the ability to attach scanned or imaged correspondence received from clients, attorneys and others related to the case		☐			
TPL.18.	Apply levels of security and access to certain processes and functions		☐			
TPL.19.	Automatically suspend certain work items or claims based on defined business rules for review at a later date		☐			
TPL.20.	Allow manual suspense of work items or individual cases and claims for review at a later date		☐			
TPL.21.	Automatically generate notices to supervisory staff when a work item or process is overdue		☐			

ID	EOHHS Requirement		Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
Estate Recovery The FA will implement a Case Tracking tool with workflow functionality that supports Estate Recovery, including:						
TPL.22.	Automatically initiate an Estate Recovery case based upon receipt of a Date of Death on a member record by the MMIS		☐			
TPL.23.	Route work items and documents related to estate recovery claims and processes to appropriate estate recovery staff		☐			
TPL.24.	Allow access to Estate Recovery cases to legal and other staff authorized by DHS on a case-specific basis		☐			
TPL.25.	Generate affidavit, estate and lien claims; voluntary receipt letters; follow-up letters; closing letters and documents; refund letters; and other necessary documents, using templates pre-populated with information from the estate recovery case management system		☐			
Casualty Recovery The FA will implement a Case Tracking tool with workflow functionality that supports Estate Recovery, including:						

ID	EOHHS Requirement		Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TPL.26.	Initiate a Casualty Recovery case based on presence of a trauma procedure or diagnosis on an adjudicated claim. Automatically generate identification, tracking and follow-up notifications for claims with trauma diagnosis codes, accident codes, and indicators as defined by DHS.		☐			
TPL.27.	Update Casualty Recovery cases based on questionnaire, SWICA and other documents received		☐			
TPL.28.	Provide the ability to store, retrieve, and update relevant program data, including member attorney and insurance company information and lien amounts and statuses		☐			
TPL.29.	Generate, track, and distribute member trauma reports as directed by the State		☐			
TPL.30.	Generate and send questionnaires to case-heads regarding possible trauma incidences to a member		☐			
TPL.31.	Provide the ability to generate, distribute, and track letters and invoices distributed to associated third parties regarding invoices		☐			

ID	EOHHS Requirement		Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TPL.32.	Generate and send a certified, lien letter to involved attorney(s) and/or insurance company(s)		☐			
TPL.33.	Generate letters to SSA and the settlement provider acknowledging receipt of settlement		☐			
TPL.34.	Process worker's compensation activity file against Medicaid eligibility data to identify individuals receiving both Medicaid and workers compensation		☐			
TPL.35.	Provide the ability to store multiple incidences of a casualty based on the date and time of the occurrence within the casualty case management system.		☐			
Outputs						

ID	EOHHS Requirement		Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TPL.36	Letters and notices required for follow-up and settlement of Casualty and Estate cases. Examples include: SWICA letter, Casualty Questionnaire, Request for Additional Information, Notice of Case Amount Due, Estate Notice of Liability, Case Settlement Request, Lien Letter, Ad-hoc letters, and other letters to be determined by the State. Letters and notices to be added and changed via a flexible administrative module allowing production of letters and notices without hard coding.		☐			
TPL.37	Casualty and Estate Recovery case management reports as specified by DHS		☐			
TPL.38.	Claims mass adjustment reports		☐			
Interfaces						
TPL.39.	Provide automatic updates of verified TPL information through an interface to the eligibility system of record		☐			
TPL.40.	Implement an automated interface to receive TPL information from the child support enforcement system for Medical Assistance children with absent parent or other medical coverage		☐			

ID	EOHHS Requirement		Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TPL.41.	Support an interface to transmit TPL information to and from the Welligent system for Early Intervention program and other system interfaces providing relevant TPL data		☐			
TPL.42.	Automate interfaces with DMV and DLT for retrieval of casualty-related information		☐			
TPL.43.	Support an interface to the EOHHS Data Warehouse update third-party liability information from the MMIS		☐			
TPL.44.	Support an interface to the State's Legal Case System		☐			
Fiscal Agent Responsibilities						
TPL.45.	Implement a unique numbering system for Casualty Recovery cases and Estate Recovery cases created in case tracking tool for use with outgoing and incoming correspondence, and reports		☐			
TPL.46.	Establish a document library for storing case documentation, indexed by unique numbering system		☐			
TPL.47.	Scan and image all correspondence received in relation to Casualty and Estate Recovery cases. Link scanned documents to case IDs in the Case Tracking tool.		☐			

ID	EOHHS Requirement		Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TPL.48.	Archive all correspondence generated in document library, indexed by unique numbering system		☐			
TPL.49	Systemically generate letters requested for each case, and mail them using any special letter instructions defined by the State (e.g., certified mail for lien notices)		☐			

ID	EOHHS Requirement		Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
Inputs						
PI.1.	Imaged or scanned documents or attachments to SURS cases tracked in the Program Integrity Case Tracking tool		☐			
PI.2.	Online updates to the tool by authorized users		☐			
Processing Provide a Program Integrity Case Tracking tool that allows the creation and assignment of SURS cases. Additional functionality specific to Program Integrity includes the following:						

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
PI.3.	Provide the ability to enter complaints and referrals from outside parties and agencies about members or providers into an electronic tracking system for fraud and abuse investigations	☐			
PI.4.	Apply and track payments received from providers	☐			
PI.5.	Establish payment arrangements for settled cases	☐			
PI.6.	Link current and historical member IDs to track and retrieve all services to a single member regardless of the number of historical changes in member ID	☐			
PI.7.	Link current and historical provider data, including group provider data, to capture all the entities under which one provider may be affiliated	☐			
PI.8.	The Case Tracking System must be deployed on the Web Foundation. (See Technical Requirements, Section 7)	☐	N/A		
PI.9.	The Case Tracking System must be integrated with the other applications through the ESB. (See Technical Requirements, Section 7)	☐			
Outputs					
PI.10.	Letters and notices required to follow-up on SURS cases. Examples include: Request for Additional Information, Claims History Reports, Ad-hoc letters, Lien Notices and other letters to be determined by the State.	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
PI.11.	Generation of a MMIS claims adjustment file for mass adjustment of claims when a case is settled	☐			
PI.12.	Accounts receivables reporting for settled cases	☐			
Interfaces The Program Integrity Case Tracking tool will support interfaces with the following systems:					
PI.13.	MMIS	☐			
PI.14.	EOHHS Data Warehouse	☐			
PI.15.	Legal Case System (PROCATS)	☐			
PI.16.	RIFANS	☐			
Fiscal Agent Responsibilities					
PI.17.	Implement a unique numbering system for all SURS cases created in the Program Integrity Case Tracking tool for use with outgoing and incoming correspondence and reports	☐			
PI.18.	Establish a document library for storing case documentation, indexed by unique numbering system	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
PI.19.	Scan and image all correspondence received in relation to identified SURS cases. Link scanned documents to case IDs in the Case Tracking tool.	☐			
PI.20.	Archive all correspondence generated in document library, indexed by unique numbering system	☐			
PI.21.	Systemically generate letters requested for each case, and mail them using any special letter instructions defined by the State (e.g., certified mail for lien notices)	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
Inputs					
CS.1.	Telephone calls from in-state and out-of-state providers of Medicaid, Global Waiver, CNOM and other medical services processed through the MMIS	☐	N/A		
Processing The State is asking Bidders to propose a Commercial Off the Shelf (COTS) or transfer application for Provider Call Center tracking software. Desired functionality is detailed in this document and will be evaluated as part of the selection process. Desired functionality includes the following requirements:					

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.2.	Enhance Provider Call Center functionality by implementing improved automated call distribution and tracking software with the ability to record and aggregate information designated by DHS by line as detailed in Section 2.4. Specific functionality will be proposed by Bidders and finalized in the design sessions.	☐			
CS.3.	Include functionality to track basic call information entered automatically or by Provider Call Center staff, including date and time of call, caller name, caller company/employer, reason for call, resolution of call, and FA staff person ID. Specific functionality will be proposed by Bidders and finalized in the design sessions	☐			
CS.4.	Maintain a detail history of Provider Call Center calls for up to three years	☐			
CS.5.	Track grievances and appeals by providers and members initiated or followed up through the Provider Call Center	☐			
CS.6.	The Call Center Tracking System must be deployed on the Web Foundation. (See Technical Requirements, Section 7)	☐	N/A		

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.7.	The Call Center Tracking System must be integrated with the other applications through the ESB. (See Technical Requirements, Section 7)	☐			
Outputs					
CS.8.	Maintain required Provider Call Center statistics and report to DHS on a daily, weekly and monthly basis or according to the reporting schedule and format specified by DHS. Desired statistics are: Number of incoming calls	☐			
CS.9.	Total number of calls answered by each staff member	☐			
CS.10.	Average number of calls answered by each staff member	☐			
CS.11.	Average call wait time by staff member	☐			
CS.12.	Average talk time by staff member	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.13.	Percent of calls answered by each staff person and cumulative FA staff in less than 30 seconds after selection of menu option during normal business hours, segregated as specified by DHS by such categories as routine and authorization services calls	☐			
CS.14.	Maintain the capability to differentiate statistics for State and FA Provider Call Center staff as well as individual staff	☐			
CS.15.	Produce and deliver weekly reports, providing the following: Produce standard reports on call completion statistics as specified by DHS. Reports will include data such as: number of attempts, completions, retries, average minutes holding time, average length of calls, number of calls receiving busy signals, number of abandoned calls. Provide data by one hour intervals or as specified by DHS.	☐			
Interfaces					
CS.16.	Maintain an interface with the MMIS for inquiry and update by authorized Provider Call Center staff	☐	N/A		

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
Fiscal Agent Responsibilities					
Location and Staffing Requirements					
CS.17.	Maintain and operate an integrated Provider Call Center that incorporates all Provider Call Center activities under the contract	☐	N/A		
CS.18.	Staff a Provider Call Center with highly trained personnel who are able to provide quality service and assistance to the Rhode Island Medical Assistance Program community, including providers, members and contracting agencies	☐			
CS.19.	Ensure Provider Call Center telephone staff has at least two years of medical claims examination/billing experience and good customer service skills	☐			
CS.20.	Locate a Provider Call Center within 20 miles of DHS Medical Assistance offices in Cranston, Rhode Island for access by up to 10 State staff. Provider Call Center personnel may be located at various sites as long as call tracking and timeliness requirements are met through automation.	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.21.	Provide sufficient toll-free lines, all necessary telephone system infrastructure and support, and maintain toll-free business lines for the Provider Call Center to meet performance requirements	☐			
CS.22.	Develop and adhere to a contingency plan for temporary or permanent increases in volumes of calls	☐			
CS.23.	Staff the Provider Call Center as required to meet performance requirements defined in Section 5	☐			
CS.24.	Staff the Provider Call Center to meet performance requirements from 8:00 a.m. to 5 p.m. Eastern Time, Monday through Friday on State work days	☐			
CS.25.	Staff the Provider Call Center to meet performance requirements after hours, weekends and holidays	☐			
CS.26.	After regular business hours, provide an automated message system to collect caller information (e.g., voice mail)	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.27.	Provide Provider Call Center staff or translation services for the following languages: Spanish	☐			
CS.28.	Provide a translation service with immediate (within 60 seconds) access to services during normal working hours	☐			
Procedures, Training and Quality Control					
CS.29.	Perform quality control on Provider Call Center staff by listening to line calls or recorded calls on a weekly basis. Report results to DHS in a format specified by DHS.	☐	N/A		
CS.30.	Develop a training curriculum for the Provider Call Center staff for review and approval by DHS, and implement the approved curriculum	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.31.	Develop and maintain current procedures for Provider Call Center staff to respond to all provider inquiries such as covered health program billing procedures and issues, claim status, system problems, prior authorizations, payment issues and general questions regarding policy and regulations. Include specific procedures for Pharmacy POS assistance as directed by DHS.	☐			
CS.32.	Refer inquiries, which cannot be answered immediately by the Provider Call Center staff, to the appropriate DHS staff as designated in documented procedures	☐			
Reliability Requirements Ensure the Provider Call Center downtime does not exceed one-half hour for any given month. In the event of system failure the Contractor shall:					
CS.33.	Notify DHS (via e-mail or telephone) of any incident of Provider Call Center downtime within one-half hour of the incident, or as soon as the FA is aware of the interruption. Provide the cause and projected duration of the incident as soon as it is known.	☐	N/A		
CS.34.	Notify providers via the Web portal of any incident of down time as directed by DHS	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.35.	Report closure measures and corrective actions within twenty-four hours of systems repair, including the actual cause, areas impacted, corrective actions and preventive measures	☐			
CS.36.	Provide an electronic notice to DHS and online users of any planned system interruption, shutdown or lost file access at least three workdays prior to the system interference. Provide notice to providers through the Web portal at the same frequency or as specified by DHS.	☐			
Pharmacy POS Assistance					
CS.37.	Provide prior authorization services in support of the Pharmacy POS system, including DHS, BHDDH and DOE claims according to the criteria specified by DHS	☐			
Performance Requirements					
EOHHS has specified the following performance requirements for the Provider Call Center:					

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.38.	Answer 90% of routine calls within 30 seconds during normal working hours. Normal working hours are defined as 8 a.m. to 5 p.m. Eastern Time, Monday through Friday, excluding State holidays.	☐	N/A		
CS.39.	Answer 95% of routine calls within 45 seconds during normal working hours	☐			
CS.40.	Answer 99% of routine calls within 60 seconds during normal working hours	☐			
CS.41.	Answer or route to voice mail 90% of routine calls within 20 seconds after hours, weekends or holidays	☐			
CS.42.	Ensure that the weekly average number of incoming calls that are blocked (calls receiving a busy signal) shall be no more than one percent	☐			
CS.43.	The weekly average abandon rate shall be no more than five percent. A call will be considered abandoned after the first thirty seconds when a caller chooses to disconnect after the introductory message and prior to being connected to a staff member or voice mail.	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
CS.44.	The weekly average wait or hold time shall not exceed one-hundred twenty seconds	☐			

O.2 Requirements Checklist for Claims Processing Requirements, Eligibility (Beneficiary Management Requirements), Managed Care Requirements, and Financial and Program Management Requirements

ID	EOHHS Requirement	Bidder Acknowledgment
Inputs		
CLM.1.	Additional claims transactions submitted in standard HIPAA formats (including ASC X12 5010 claims transactions and NCPDP D.0)	☐
CLM.2.	Additional prior authorization transactions submitted in standard HIPAA format by agencies or providers, or real-time authorizations generated by the Care Management System, including modifications to DCYF prior authorization transactions and acceptance of authorizations from programs administered by DHS, BHDDH and DOH such as Shared Living, Community and Assisted Living Waivers, etc.	☐
CLM.3.	Prior authorizations in standard HIPAA format submitted by providers through the provider Web portal	☐
CLM.4.	Claims with attachments in standard HIPAA format (when rule is finalized) submitted by providers through the provider Web portal	☐
CLM.5.	DCYF member data from RICHIST to support accurate federal reporting, such as trust, IV-E, Individual Education Plan (IEP), personal care and child support information	☐
CLM.6.	Primary Care Physician data from the managed care plans entered through the Web portal or other automated input in proprietary format as specified by DHS	☐
CLM.7.	Minimum Data Set (MDS) records received from DOH or the EOHHS Data Warehouse to support RUG pricing	☐
Processing		

ID	EOHHS Requirement	Bidder Acknowledgment
General Enhanced Claims Processing		
CLM.8.	Process additional claims transactions for State agencies in standard HIPAA formats including billing and rendering provider IDs as directed by DHS	☐
CLM.9.	Process claims for additional CNOMS, waivers and agency programs, including Adaptive Telephone Equipment, Breast and Cervical Cancer Treatment Program (BCCTP) screenings, Developmentally Disabled (DD) Day and Supported Employment, Substitute Care, all Residential Diversion programs, Reunification Support, Substance Abuse Non-IMD Residential, Substance Abuse Outpatient, Methadone, and other programs designated by DHS during design sessions	☐
CLM.10.	Process claims identifying performing or rendering providers in addition to billing providers for programs such as Early Intervention, Community and Assisted Living Waivers and Nursing Home Transition Services, and other programs specified by DHS during design sessions	☐
CLM.11.	Process prior authorizations received through the provider Web portal and post results (accept, deny or pend) on the Web portal	☐
CLM.12.	Accept updates to pended prior authorizations received through the provider Web portal, process updates and determine outcomes, and post results	☐
CLM.13.	Process claims with attachments received through the provider Web portal, automatically link attachments to claims, and post results (accept, deny or pend) on the Web portal	☐
CLM.14.	Generate and distribute Medicare premium payments as specified by DHS	☐

ID	EOHHS Requirement	Bidder Acknowledgment
CLM.15.	Accept (according to DHS-approved methods) and post received Medicare premium payments, and issue notifications of past due payments. Disenroll clients missing payments according to DHS-specified criteria.	☐
CLM.16.	Process claims according to new reimbursement methodologies as directed by DHS to support national and State initiatives. Examples include methodologies to support medical homes, ACA provisions, payment for performance, incentive payments, etc.	☐
CLM.17.	Allow payment of a single provider through multiple methodologies, depending on client characteristics and services provided	☐
DCYF Claims Processing		
CLM.18.	Process DCYF claims, and assign the appropriate funding source according to hierarchy established by DHS	☐
CLM.19.	Process DCYF claims for residential providers at provider-specific rates, which are maintained in the MMIS. Pay lead agency (billing) providers at rates specific to rendering providers.	☐
CLM.20.	Continue to process DCYF claims for community-based services providers by HCPCS procedure	☐
CLM.21.	Pay designated DCYF claims at 100 percent of billed rates	☐
CLM.22.	Process CNOM claims for Residential Diversion and Reunification Support programs, and designate the appropriate funding source	☐
BHDDH Claims Processing		
CLM.23.	Process claims for the Methadone and Substance Abuse Outpatient programs, including billing and performing providers, based on HCPCS procedure codes	☐

ID	EOHHS Requirement	Bidder Acknowledgment
CLM.24.	Process claims for Substance Abuse Non-IMD residential providers	☐
CLM.25.	Process claims for DD Day and Supported Employment program claims as directed by BHDDH and DHS	☐
DHS's DEA Division Claims		
CLM.26.	Process claims for CNOMS, Elderly Population Transportation, Assisted Living and Home Care, and other DEA Division programs	☐
DOH Claims		
CLM.27.	Automate designation of the funding source for ADAP and ADAP CNOM program claims processed through the MMIS	☐
CLM.28.	Process claims for the Women's Cancer Screening Program	☐
DHS Nursing Home Claims		
CLM.29.	Provide the ability to process electronic nursing home claims in standard HIPAA format, including editing, adjudication and payment, based on member-specific RUG score billed on inpatient residential facility (e.g., long-term care) claims	☐
CLM.30.	Provide the ability to generate case mix index information to be used for rate setting purposes and for distribution to providers as directed by the State for residential care, nursing facilities, long-term care providers, and other long-term care services	☐
CLM.31.	Maintain pricing data based on RUGs	☐
CLM.32.	Identify, distinguish, and maintain interim, final or multiple residential facilities (e.g. long-term care) rates per provider or provider ID as directed by DHS	☐
CLM.33.	Maintain MDS case mix information received from residential care facilities	☐

ID	EOHHS Requirement	Bidder Acknowledgment
Pharmacy Point-of-Sale		
CLM.34.	Continue to process pharmacy claims for DHS, DOH (ADAP), DEA (RIPAE) and BHDDH (CMAP), and expand processing for additional programs as requested by DHS	☐
CLM.35.	Support NCPDP D.0 standards for pharmacy point-of-sale electronic transactions	☐
Provider Web Portal		
.CLM.36 .	Enhance the provider Web portal to accept electronic prior authorizations and claims with attachments	☐
Support of National Initiatives		
CLM.37.	Implement ICD-10 functionality/crosswalk to support billing, processing/editing, and payment of claims with ICD-10 code set	☐
CLM.38.	Modify MMIS to support editing and adjudication of claims and prior authorization requests based on diagnosis and procedure code matching upon implementation of ICD-10 code set and other measures specified by DHS	☐
CLM.39.	Modify the MMIS system and supporting inputs and outputs, to use the National Provider Identifier as the primary Provider key. Unique identifier information should include, but is not limited to: all practice locations, provider types, specialties, authorization/enrollments/licensing for services, and all other appropriate information for that provider as a logical record linked to the one provider number.	☐
CLM.40.	Assign unique provider identification numbers to non-NPI (atypical) providers as specified by DHS	☐
Outputs		

ID	EOHHS Requirement	Bidder Acknowledgment
CLM.41.	Updates to the Care Management System of claims submitted, pended and adjudicated, indicating the MMIS as the data source on a schedule specified by DHS. Claims information will include dates of service, member ID, billing and performing provider IDs, procedures, diagnoses and other data specified by DHS during the design sessions.	☐
CLM.42.	Updates to the Care Management System of prior authorizations submitted, pended, and approved, indicating the MMIS as the data source on a schedule specified by DHS. Prior authorization information will include dates of service, member ID, billing and performing provider IDs, procedures, amounts, types of service and other data specified by DHS during the design sessions.	☐
CLM.43.	Enhanced financial information on claims records to support automated federal and State reporting as described in Section 5	☐
CLM.44.	Adjudicated claims data for payment processing through the State financial system	☐
CLM.45.	Adjudicated claims data for additional claims for inclusion in MMIS history and the EOHHS Data Warehouse	☐
CLM.46.	Adjudicated claims data for inclusion on provider remittance advices and 835s	☐
CLM.47.	Claims financial data to DHS finance staff for appropriate claiming and reporting	☐
CLM.48.	Premium processing financial data to DHS finance staff for appropriate claiming and reporting	☐
CLM.49.	Capitation payment data to DHS finance staff for appropriate claiming and reporting	☐
CLM.50.	Standard reports specified by DHS (to be defined at a high level), which will be defined during the design sessions	☐
Interfaces		

ID	EOHHS Requirement	Bidder Acknowledgment
CLM.51.	Implement a long-term care interface between the source of the MDS version 3 (MDS 3.0) and the MMIS for the purposes of establishing RUG rates for provider reimbursement	☐
CLM.52.	Implement an interface with the Care Management System to receive prior authorizations from the CMS, update the CMS with claims and encounter data, prior authorizations and issue alerts, sanctions, eligibility flags, etc., as specified by DHS	☐
CLM.53.	Maintain and enhance the interface with RIFANS to support automation of federal and State reporting, and allocation of claims, premiums, capitation payments and other financial transactions processed through the MMIS	☐
CLM.54.	Develop and maintain interfaces between the MMIS and RIFANS with the Medicaid budget forecasting model	☐
Fiscal Agent Responsibilities		
CLM.55.	Receive, control, edit and adjudicate claims for agencies' programs specified by DHS	☐
CLM.56.	Enroll providers and maintain provider information for billing and rendering providers designated by the agencies, including atypical providers	☐
CLM.57.	Maintain provider-specific rates for DCYF billing and performing providers	☐
CLM.58.	Maintain MDS case mix information received from residential care facilities through DOH or the EOHHS Data Warehouse	☐
CLM.59.	Generate standard reports not produced by the EOHHS Data Warehouse	☐
CLM.60.	Maintain report distribution reports, including persons receiving reports and frequency of production	☐

ID	EOHHS Requirement	Bidder Acknowledgment
Inputs The MMIS will accept the following additional inputs. Note that eligibility will be input through one of the current methods for direct entry into the MMIS.		
ELG.1.	Member-specific data from RIDE to support all non-emergency claims processing and Medicare premium information from the Care Management System	☐
ELG.2.	Eligibility information for the following programs: BCCTP, Developmental Disabilities Day and Supported Employment CNOM, Substitute Care CNOM, all Residential Diversion, Reunification Support CNOM, Substance Abuse Non-IMD Residential, Substance Abuse Outpatient, Methadone, and other programs designated by DHS during design sessions	☐
ELG.3.	DCYF member data from RICHIST to support accurate State and federal reporting, such as trust, IV-E, IEP, personal care and child support information	☐
ELG.4.	Additional or modified data from InRhodes during implementation of Phases I and II of the State's new eligibility system. Modify the MMIS interface to accurately and receive and process data.	☐
Processing		
ELG.5.	Add Elderly Population Transportation eligibility indicator to member record in MMIS based on applicable eligibility category code or enrollment segment for DEA Adult Day Care and Home Health CNOMs	☐

ID	EOHHS Requirement	Bidder Acknowledgment
ELG.6.	Add Early Intervention (EI) eligibility indicator to member record in MMIS based on EI eligibility segment from State's eligibility system, InRhodes	☐
ELG.7.	Enhance the current claims edit check on age restrictions for EI claims to include the new EI indicator	☐
ELG.8.	Add a SPMI program indicator to the member record in MMIS based on the eligibility criteria defined by BHDDH	☐
ELG.9.	Provide online, updatable letter templates for member letters with the ability to add free-form text specific to a member	☐
ELG.10.	Provide member information needed to support the new Care Management application	☐
ELG.11.	Maintain eligibility information for the Adaptive Telephone Equipment CNOM	☐
ELG.12.	Maintain eligibility information for all waiver and CNOM programs identified in this RFP as well as additional programs identified in the design sessions	☐
ELG.13.	Maintain eligibility information for the MA member to remain in Rlte Care under the Reunification Support CNOM after Medicaid eligibility is discontinued according to the State's eligibility system, InRhodes. Add a DCYF wrap-around service indicator to the member record in the MMIS based upon applicable eligibility criteria. Allow wrap-around services (fee-for-service carve outs) to continue to be paid once DCYF member returns to standard MA eligibility.	☐
ELG.14.	Maintain eligibility for the ADAP CNOM program. Differentiate between the standard ADAP and ADAP CNOM programs	☐
ELG.15.	Automate the eligibility determination for the Women's Cancer Screening CNOM	☐
ELG.16.	Add a BCCTP recertification date to member eligibility record in the MMIS	☐

ID	EOHHS Requirement	Bidder Acknowledgment
ELG.17.	Allow for Respite eligible members to continue to show Respite Waiver eligibility until age 21 when LTC eligibility segment begins. Automatically discontinue eligibility for Respite Waiver programs when the child reaches age 21.	☐
ELG.18.	Automate the tracking and deduction of patient liability (long-term care client share) for the following programs. Incorporate logic into the MMIS to automatically determine which provider is responsible for collecting client share when more than one provider bills. Assisted Living	☐
ELG.19.	Personal Choice	☐
ELG.20.	Habilitation	☐
ELG.21.	PACE	☐
ELG.22.	DHS's DEA Adult Day Care CNOM (copay)	☐
ELG.23.	DHS's DEA Home Care CNOM (copay)	☐
ELG.24.	Other long-term care programs as needed	☐
Affordable Care Act (ACA)		
Implement the new mandatory Medicaid Eligibility categories defined by the Affordable Care Act (ACA)		
ELG.25.	Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents) with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014	☐
ELG.26.	As of January 1, 2014, modify the MMIS to support the change in the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL	☐
ELG.27.	If RI decides to offer the Basic Health Program, eligible individuals would also include residents with income between 133% and 200% of the FPL	☐

ID	EOHHS Requirement	Bidder Acknowledgment
Outputs		
ELG.28.	Enhanced extracts provided to the Human Resources Data Warehouse to include additional member data requirements	☐
ELG.29.	Online inquiry screens to display Medicare premium information, medical home information, transportation, waiver and CNOM eligibility, including historical eligibility dates as specified by DHS during design sessions	☐
Interfaces		
ELG.30.	The new Care Management application	☐
ELG.31.	The new Case Tracking application for program integrity, estate recovery, and casualty cases	☐
ELG.32.	An interface with RICHIST to access additional member information, such as trusts, IV-E eligibility, etc. needed for accurate accounting and financial reporting	☐
ELG.33.	Interfaces and functionality for the MMIS to interact with the Health Insurance Exchange and Health Information Exchange	☐
Fiscal Agent Responsibilities		
ELG.34.	Receipt of data from new sources identified in Section 2.1.1	☐
ELG.35.	Maintenance of member data with modifications indicated in Section 2.1.2	☐
ELG.36.	Production of reports and outputs as defined in Section 2.1.3	☐
ELG.37.	Reconciliation of member data against source databases and the EOHHS Data Warehouse as directed by DHS	☐

ID	EOHHS Requirement	Bidder Acknowledgment
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ID	EOHHS Requirement	Bidder Acknowledgment
Inputs		
The FA will accept the following inputs to support enhancements to the managed care functions through EDI or the provider Web portal:		
MC.1.	Eligibility transactions (enrollments, re-enrollments, disenrollments and reinstatements) from the eligibility system of record (now InRhodes) as documented in the MMIS Systems Documentation	☐
MC.2.	Encounter data in HIPAA 5010 format from the managed care plans for Rlte Care (including Rlte Share) and Rhody Health Partners and from the Rlte Smiles Dental Benefits Manager	☐
MC.3.	Premium copay data from the eligibility system of record	☐
MC.4.	Monthly provider data in proprietary format, including participating provider data and primary care provider assignments, from the managed care contractors using NPI as the provider ID	☐
MC.5.	A monthly proprietary file including drugs and J-code procedures provided by managed care contractors and are eligible for rebate	☐
Processing		
Enrollment Maintenance Requirements		
MC.6.	Process enrollments, re-enrollments, disenrollments and reinstatements based on data received from the eligibility system of record	☐
MC.7.	Maintain program indicators based on eligibility data and criteria specified by DHS, such as Communities of Care incentive indicators, specific conditions (health-acquired) or other program indicators	☐
MC.8.	Generate day-specific enrollment, re-enrollment, disenrollment and reinstatement transactions to Rite Care managed care plans using approved HIPAA transactions in 834 format on a daily basis or as specified by DHS	☐

ID	EOHHS Requirement	Bidder Acknowledgment
MC.9.	Generate day-specific enrollment, re-enrollment, disenrollment and reinstatement transactions to Rhody Health Partners and the Dental Benefits Manager for Rlte Smiles using approved HIPAA transactions in 834 format on a daily basis or as specified by DHS	☐
MC.10.	Investigate rejected enrollment transactions and coordinate updates of the MMIS and the eligibility system of record as necessary to reconcile information in all systems according to procedures specified by DHS	☐
Encounter Processing Requirements		
MC.11.	The FA will support processing of encounters and adjustments to encounters in standard HIPAA 5010 format. The FA will be required to support additional encounter processing if the number of contractors is increased or if DHS develops additional managed care programs.	☐
MC.12.	Receive and process encounter transactions from Rlte Care (including Rlte Share) and Rhody Health Partners managed care organizations and the Rlte Smiles Dental Benefits Manager in HIPAA 5010 format on a monthly basis or as specified by contract	☐
MC.13.	Edit encounter transactions according to criteria specified by DHS in design sessions. Determine if the encounter data is timely, accurate, complete, and complies with program policy.	☐
MC.14.	Edit encounters to ensure that performing and referring providers are identified on standard transactions using the NPI unless otherwise specified by DHS	☐
MC.15.	Edit NPIs for performing providers on encounter data against provider data supplied by the managed care contractors through a proprietary file or through the provider Web portal to verify provider participation with the managed care contractor	☐

ID	EOHHS Requirement	Bidder Acknowledgment
MC.16.	Reject and report rejected encounters to the submitting organization. Respond to organizations within five work days of data submission regarding encounter data submission errors	☐
MC.17.	Investigate rejected encounter transactions and coordinate update of the MMIS and the eligibility system of record as necessary to reconcile information in all systems according to procedures specified by DHS	☐
MC.18.	Maintain an online log of all encounter submissions and results	☐
MC.19.	Reject an entire batch of encounters if it fails the tolerance levels of submission edits as defined by the Department	☐
MC.20.	Retain a unique submission ID in individual records for accepted files, and return back to the submitter totals of encounters pending, rejected and accepted by provider by reason for pending or rejected encounters	☐
MC.21.	Allow adjustment of accepted encounter records using standard HIPAA 5010 transactions, according to procedures specified by DHS	☐
MC.22.	Provide the ability to track adjustments, corrections, and link adjusted encounters to the original encounter submission	☐
MC.23.	Accept and maintain data in a format specified by DHS to support national initiatives such as identification of health-acquired conditions, Communities of Care incentives, etc.	☐
Rite Share Processing Requirements The FA will continue to perform Rite Share processing according to current MMIS Systems Documentation and incorporate modifications to support required modifications, including:		
MC.24.	Generate employer-sponsored insurance premiums to members or employers as directed by DHS	☐

ID	EOHHS Requirement	Bidder Acknowledgment
MC.25.	Expand identification of TPL activity from the eligibility system, managed care contractors or other sources identified by DHS. Receive and process monthly TPL updates from managed care contractors.	☐
MC.26.	Share TPL data with the Rlte Share Unit on a timely basis through procedures designated by DHS	☐
MC.27.	Interface with the Rlte Share Access database as specified in MMIS Systems Documentation and as modified during design sessions	☐
MC.28.	Provide online access to 24 months of member premium data, including payments to employers/members and invoices issued, paid and outstanding for member cost share amounts	☐
Rlte Care Premium Processing Requirements The FA will continue to process Rlte Care premiums owed by members and implement modifications required to support required enhancements:		
MC.29.	Suppress monthly invoices for cases in which no address is known	☐
MC.30.	Interface with the eligibility system to ensure accurate and timely information is provided to support reporting of payments made, insufficient funds, etc.	☐
MC.31.	Track and report Premium Collection Accounts Receivable	☐
MC.32.	Maintain historical information on premium accounts receivable (up to 24 months)	☐
MC.33.	Maintain premium collection customer services through the Provider Call Center	☐
MC.34.	Maintain and support Premium Payment options as defined by DHS (credit, debit, ACH, cash payment sites, etc.)	☐
MC.35.	Support new legislation which requires members to be disenrolled for a total of 4 months if the premium is not paid for two months. Disenrollment for 4 months will be enforced even if member pays past due premiums.	☐

ID	EOHHS Requirement	Bidder Acknowledgment
MC.36.	Provide the ability to write-off premium payments due according to criteria specified by DHS. Generate write-off transactions including funding sources and submit to DHS Finance for processing and financial reporting.	☐
Other Requirements		
MC.37.	Display detailed encounter data and adjustments on member and provider displays in the MMIS, Care Management System, and the provider Web portal, including dates, billing and performing providers, member, procedures, diagnoses and charges if available	☐
MC.38.	Process rebates for pharmaceuticals and J-code procedures provided by managed care contractors	☐
Outputs The FA will produce standard reports and other outputs based on encounters received from the managed care contractors. DHS anticipates that the majority of reports based on encounters will be generated through the EOHHS Data Warehouse. In certain cases, the MMIS may be required to generate the reports. For example, reports on capitation or premium payments, accounts receivable and reports on pending or rejected encounters.		
MC.39.	Produce and distribute standard reports from encounter processing, enrollment and capitation data as specified by DHS	☐
MC.40.	Provide the ability for ad hoc reporting to cover queries against encounter data and all statistical information related to encounter submissions	☐
MC.41.	Produce standard and ad hoc reports from encounter data to support national and State initiatives, such as advanced medical homes, medically acquired conditions, HEDIS, CAPS and other efforts	☐
MC.42.	Generate and disseminate reports to DHS according to the report distribution list	☐
MC.43.	Provide automated reports of managed care contractors that do not resubmit corrected encounters within fifteen calendar days, or as required by the contract, and submit them to DHS on a weekly basis	☐

ID	EOHHS Requirement	Bidder Acknowledgment
MC.44.	Provide reporting capabilities to cover submitted, accepted, rejected, corrected, and resubmitted encounter records	☐
MC.45.	Generate managed care payment transactions in 820 format on a monthly basis	☐
MC.46.	Generate standard HIPAA 835 data and remittance advices to managed care organizations detailing premiums paid, including detail data on clients and time frames	☐
MC.47.	Provide monthly reports on rebates processed for pharmaceuticals and J-code procedures provided by managed care contractors	☐
Interfaces The FA will continue to support the following interfaces including modifications needed to support required enhancements:		
MC.48.	Maintain an interface with the eligibility system of record to support maintenance of eligibility and enrollment data for participation in Rhode Island's managed care programs	☐
MC.49.	Maintain an interface with the EOHHS Data Warehouse to provide updated encounters and adjustments, primary care and other provider data, member-specific indicators, and data on capitation and premium payments	☐
MC.50.	Maintain an interface with the RI Division of Taxation to perform Tax Intercept processing as documented in the MMIS Systems Documentation	☐
Fiscal Agent Responsibilities		
MC.51.	Maintain documentation of all contractors' performance of encounter data submission activities, including edit results, volume and consistency of submissions	☐
MC.52.	Designate and maintain sufficient dedicated staffing levels to support all functions of encounter data processing for managed care contractors	☐

ID	EOHHS Requirement	Bidder Acknowledgment
MC.53.	Make recommendations to DHS when new technologies become more viable for data collection	☐
MC.54.	Provide technical assistance to the managed care contractors regarding encounter data submission activities including assisting contractors with instructions on how to submit encounter data. Review encounter data reports, and contact the appropriate contractors to discuss and assist with error and issue resolution. Provide training and assistance to new contractors on encounter data submission and test submission files.	☐
MC.55.	Reconcile fee-for-service claims against encounter data on an annual basis or at a frequency specified by DHS to identify duplicate or suspect duplicate payments for services to managed care clients	☐
MC.56.	Investigate and report duplicate payments made by DHS and recoup payments as directed by DHS	☐
MC.57.	Accurately capture and retain encounter data for two years in the MMIS and without limitation in the EOHHS Data Warehouse	☐
MC.58.	Refresh encounter data in the EOHHS Data Warehouse with MMIS encounter data daily or at a frequency specified by DHS	☐
MC.59.	Accurately capture and maintain the encounter data and submission records in a database for reporting purposes. Maintain up to 60 months of historical data.	☐

ID	EOHHS Requirement	Bidder Acknowledgment
Inputs		
The FA will incorporate the following additional data sources into the EOHHS Data Warehouse:		

ID	EOHHS Requirement	Bidder Acknowledgment
DW.1.	CNOM expenditure data to be incorporated into MMIS including the following CNOM data as well as any additional CNOMs identified by DHS during the design sessions: Community Health Centers	☐
DW.2.	Adaptive Telephone Equipment	☐
DW.3.	Transportation (RIDE)	☐
DW.4.	DD Day & Supported Employment	☐
DW.5.	Residential Diversion CBH	☐
DW.6.	Residential Diversion CW	☐
DW.7.	Residential Diversion Voluntary	☐
DW.8.	Reunification Support	☐
DW.9.	Women's Cancer (BCCTP) Screening	☐
DW.10.	Substance Abuse Non-IMD Residential	☐
DW.11.	Methadone	☐
DW.12.	Substance Abuse Outpatient	☐
DW.13.	Managed care data from the MCOs incorporating additional data elements from the encounter (5010) transaction, PCP data and member-specific data received through proprietary files or the provider Web portal	☐
DW.14.	Additional claims data for claims processed through the MMIS as described in section 2 of this document	☐

ID	EOHHS Requirement	Bidder Acknowledgment
DW.15.	Data currently stored in the RIte Share Access Database for performance measurement, such as employer information, benefits, open enrollment periods and premium payment information	☐
DW.16.	Health outcomes data currently used to measure performance, benchmarking and calculate outcome measures, such as: Public health databases	☐
DW.17.	Hospital discharge data	☐
DW.18.	Vital statistics	☐
DW.19.	National substance abuse data sources	☐
DW.20.	Quality metrics such as HEDIS	☐
DW.21.	Data from the Care Management System, including care plans and prior authorization data	☐
DW.22.	KIDSNET data, including immunization, hearing loss and lead screenings from DOH	☐
DW.23.	Lead paint, lead inspection, home visitation data, developmental risk assessments, newborn hearing assessments, newborn blood spot and audiology testing results and follow-up, birth defects, and other data from DOH identified by DHS during the design sessions	☐
DW.24.	BHDDH behavioral health data on case plans, assessments, services and TPL, as well as data on client admits, discharges and outcomes	☐
DW.25.	Early Intervention Welligent data, including case plans, assessments, services and TPL	☐
DW.26.	DLT wage and unemployment insurance data	☐
DW.27.	RIDE data warehouse data (nutrition)	☐

ID	EOHHS Requirement	Bidder Acknowledgment
DW.28.	DOC prison reentry and WINFACTS	☐
DW.29.	DCYF RICHIST data (selected data related to medical and behavioral health services)	☐
DW.30.	Encounter data from the Transportation Broker	☐
Processing		
DW.31.	Accept, edit and process new data from identified sources according to schedule defined by the DHS	☐
DW.32.	Produce standard and ad hoc reports as specified in this document and as otherwise defined by DHS during design sessions. (Note: examples of these reports or some limitations must be provided for the RFP.)	☐
Outputs		
DW.33.	Generate standard reports to support federal reporting as defined in Section 2.3	☐
DW.34.	Generate standard reports to support program reporting as defined in Section 2.4	☐
DW.35.	Generate standard reports to support financial reporting as defined in Section 2.5	☐
DW.36.	Provide ad hoc reporting by FA staff (Note: must define volume or limit.)	☐
DW.37.	Support ad hoc reporting by authorized DHS and other agency staff and contractors	☐
Interfaces		
DW.38.	Interfaces necessary to support new data source requirements as specified in Section 2.2.1	☐
DW.39.	Interfaces necessary to support federal, program and financial reporting as specified in Sections 2.3, 2.4 and 2.5	☐

ID	EOHHS Requirement	Bidder Acknowledgment
Fiscal Agent Responsibilities		
DW.40.	Maintain data and process updates on frequencies specified by DHS	☐
DW.41.	Produce reports on frequencies specified	☐
DW.42.	Maintain current system and user documentation throughout the term of the contract. Update documentation within 30 days of a change to the system.	☐
DW.43.	Maintain sufficient database specialists and system developers with skills to meet the requirements of this RFP	☐
DW.44.	Provide training to new users at least monthly for up to 30 users per month	☐
DW.45.	Provide refresher training sessions and training on new data and features for current users at least monthly for up to 100 users per month	☐
DW.46.	Refresh data on a schedule specified by DHS	☐

ID	EOHHS Requirement	Bidder Acknowledgment
Inputs		
The FA will receive and incorporate all program expenditures to automatically calculate federally mandated reports unless otherwise specified by EOHHS during design sessions. Inputs will include the following:		
FR.1.	CNOM expenditure data including the following CNOM data as well as any additional CNOMs identified by DHS during the design sessions: Community Health Centers	☐
FR.2.	Adaptive Telephone Equipment	☐
FR.3.	Transportation (RIDE)	☐
FR.4.	DD Day & Supported Employment	☐

ID	EOHHS Requirement	Bidder Acknowledgment
FR.5.	Residential Diversion CBH	☐
FR.6.	Residential Diversion CW	☐
FR.7.	Women's Cancer Screening	☐
FR.8.	Substance Abuse Non-IMD Residential	☐
FR.9.	Methadone	☐
FR.10.	Substance Abuse Outpatient	☐
FR.11.	Reunification Support (DCYF)	☐
FR.12.	Residential Diversion Voluntary	☐
FR.13.	Additional FACN transactions (payment transactions that are not claims- or client-specific)	☐
FR.14.	Additional claims data	☐
FR.15.	DCYF member data as specified in Section 2.2 to establish financial claiming hierarchy for accurate FMAP reporting	☐
Processing		
FR.16.	Accept, edit and process transactions to produce accurate federal reports	☐
Outputs The FA will develop or modify the following standard reports to support accurate federal reporting with appropriate crosswalks to State RIFANS codes:		
FR.17.	Incorporate all program expenditures to automatically calculate the following federally required reports, including, but not limited to: CMS 64	☐
FR.18.	CMS 21	☐

ID	EOHHS Requirement	Bidder Acknowledgment
FR.19.	CMS 21b	☐
FR.20.	CMS 37	☐
FR.21.	Create automated standard reports to support federal claiming for the Global Waiver program	☐
FR.22.	Automate currently manually compiled expenditures for management of FMAP and assignment of FMAP rate to service expenditures and recoveries for services processed by the MMIS for DHS and other agencies	☐
FR.23.	Create standard reports defined by the State to compare program expenses to budgeted expenses for the State and federal fiscal year-to-date, prior State and federal fiscal year, and projected through the remainder of the State and federal fiscal year	☐
Interfaces		
FR.24.	Enhance the MMIS interface with the State's accounting systems, RIFANS, to support automation of federal reports	☐
FR.25.	Support an interface between the MMIS and EOHHS Data Warehouse to support automation of federal reports	☐
Fiscal Agent Responsibilities		
FR.26.	Produce federal reports according to federally mandated timelines	☐

ID	EOHHS Requirement	Bidder Acknowledgment
Inputs		

ID	EOHHS Requirement	Bidder Acknowledgment
PR.1.	The FA will process inputs as necessary to meet the following program reporting requirements. It is anticipated that all program reports will be generated from the EOHHS Data Warehouse except for operational reports that require MMIS data or as otherwise specified by DHS during design sessions.	☐
Processing		
PR.2.	Real-time access to case management data	☐
PR.3.	Flexibility to handle numerous global or episodic reimbursement methodologies for a single provider	☐
PR.4.	Flexibility to handle numerous pay-for-performance options	☐
PR.5.	Ability to differentiate FMAP based on DHS-specified criteria	☐
PR.6.	Develop and produce standard reports to support the analysis of DHS and other agency medical programs, including, but not limited to, fee for service, CNOM and Global Waiver programs	☐
PR.7.	Develop standard reports to measure progress against DHS and other agency goals, initiatives, and policy changes, including, but not limited to, policy initiatives, budget initiatives, Affordable Care Act requirements and grant opportunities	☐
PR.8.	Automate reports to support caseload reporting and other legislative and program management requirements	☐
PR.9.	Automate reports to support accurate forecasting of program costs	☐
PR.10.	Automate reports to support evaluation of cost-containment and quality improvement initiatives	☐
PR.11.	Automate reports to support identification of high-cost cases to better focus utilization review and case management programs	☐

ID	EOHHS Requirement	Bidder Acknowledgment
Outputs		
The FA will generate the following standard reports to support program reporting from the EOHHS Data Warehouse. Reports will be produced from the MMIS only if data is not available in the EOHHS Data Warehouse (for example, operational data). Reports will support DHS and other agencies processing claims through the MMIS.		
PR.12.	Reports currently used to support monthly Quality of Care reviews	☐
PR.13.	'What If' reports and scenarios on member populations and provider groups	☐
PR.14.	Reports currently run out of the Rlte Share database to analyze the cost effectiveness of the program	☐
PR.15.	Reports on HEDIS or HEDIS-like measures	☐
PR.16.	Reports currently used to monitor plan performance and calculate outcomes measures as part of performance goal programs	☐
PR.17.	Reports currently produced for the DHS monthly financial and program indicators meeting	☐
PR.18.	Reports measuring against adherence to agencies' goals, objectives, and program policy	☐
Interfaces		
PR.19.	Implement an interface and functionality to support Health Information Exchange reporting	☐
Fiscal Agent Responsibilities		
PR.20.	Produce program reports according to State-mandated timelines	☐

ID	EOHHS Requirement	Bidder Acknowledgment
Inputs		

ID	EOHHS Requirement	Bidder Acknowledgment
FIN.1.	Accept DCYF member data stored in RICHIST to support accurate assignment of funding category and FMAP according to a hierarchy established by DHS and DCYF	☐
Processing		
FIN.2.	Review, update and enhance the crosswalk between the MMIS and RIFANS budget categories as directed by DHS	☐
FIN.3.	Balance (reconcile) expenditures between RIFANS and the MMIS	☐
FIN.4.	Automate assignment of FMAP to service expenditures and recoveries to the extent specified by DHS	☐
FIN.5.	Implement or enhance an automated interface between RIFANS and the MMIS	☐
FIN.6.	Allow for automated updates to Medicaid Budget Forecasting including, but not limited to the following functionality: Updating an Incurred But Not Reported Model (IBNR)	☐
FIN.7.	Re-project spending at any point throughout the year	☐
FIN.8.	Automate rate updates in MMIS	☐
Outputs		
FIN.9.	Standard financial management reports and/or a dashboard on a daily, weekly, monthly, quarterly, and annualized basis	☐
FIN.10.	Standard MMIS operations management reports and/or a dashboard on a daily, weekly, monthly, quarterly, and annualized basis	☐
FIN.11.	Reports currently used to support rate setting	☐
FIN.12.	Standard reports used to formulate the budget	☐

ID	EOHHS Requirement	Bidder Acknowledgment
FIN.13.	Reports currently manually compiled for management of FMAP and assignment of an FMAP rate to service expenditures and recoveries	☐
FIN.14.	Reports showing program expenses compared to budget State fiscal year to date, last State fiscal year and projected expenses through the end of the current State fiscal year	☐
Interfaces		
FIN.15.	Enhance the interface with the State's accounting system, RIFANS, to support automation of financial reporting	☐
Fiscal Agent Responsibilities		
FIN.16.	Maintain the crosswalk between the MMIS and RIFANS budget categories, making updates as necessary to support accurate automated reporting or as directed by DHS	☐

ID	EOHHS Requirement	Bidder Acknowledgment
SP.1.	Enforce role-based, member-based, program-based and field-based security to enable efficient use of new enhancements and must, at a minimum, include: Protection of data from State users without a need to know as specified by DHS at the field, member and program level	☐
SP.2.	Protection of data from providers with access to the Care Management System	☐

ID	EOHHS Requirement	Bidder Acknowledgment
SP.3.	Make EOHHS Data Warehouse data accessible to authorized users based DHS-specified criteria at the field, member and program level Maintain a secure site for automated exchange of data with providers, contracted agencies and other entities sharing data with the MMIS, Human Resources Data Warehouse, Care Management System or other data sources identified by DH	☐
SP.4.	Use State secured e-mail as directed by DHS	☐

O.3 Requirements Checklist for Technical Enhancements

ID	EOHHS Requirement	Bidder Acknowledgment
WF.1	The Web Foundation must have a development environment.	☐
WF.2	The Web Foundation must have a testing environment.	☐
WF.3	The Web Foundation must have a production environment	☐
WF.4	The Web Foundation must create a server cluster in each architectural tier.	☐
WF.5	The Web Foundation server clusters must have high availability.	☐
WF.6	The Web Foundation server clusters must be load balanced.	☐
WF.7	The Web Foundation must include a presentation tier server cluster.	☐
WF.8	The Web Foundation must include an application tier server cluster.	☐
WF.9	The Web Foundation must include a data tier server cluster.	☐
WF.10	The Web Foundation servers must be able to scale vertically, up to the physical limitations of the selected hardware and software.	☐
WF.11	The Web Foundation server clusters must be able to scale horizontally up to the physical limitations of the selected hardware and software.	☐
WF.12	The Web Foundation will provide a Web server (software) in the presentation tier.	☐

ID	EOHHS Requirement	Bidder Acknowledgment
ESB.1	The ESB will have the ability to accept request messages using HTTP.	☐

ID	EOHHS Requirement	Bidder Acknowledgment
ESB.2	The ESB will have the ability to accept request messages using Web Service protocols.	☐
ESB.3	The ESB will have the ability to accept request messages based on a location in the file system.	☐
ESB.4	The ESB will have the ability to accept request messages using EDI.	☐
ESB.5	The ESB will include an integration gateway to the MMIS if necessary.	☐
ESB.6	The ESB will have the ability to respond to request messages synchronously.	☐
ESB.7	The ESB will have the ability to respond to request messages asynchronously.	☐
ESB.8	The ESB will have the ability to validate messages that are received according to a defined XML schema.	☐
ESB.9	The ESB will have the ability to transform messages based on a transformation mapping.	☐
ESB.10	The ESB will have the ability to route messages based on message content and routing subscriptions.	☐
ESB.11	The ESB will have the ability to respond to request messages using HTTP.	☐
ESB.12	The ESB will have the ability to respond to request messages using Web Service protocols.	☐
ESB.13	The ESB will have the ability to respond to request messages using a location in the file system.	☐
ESB.14	The ESB will have the ability to respond to request messages using EDI.	☐
ESB.15	The ESB will have the ability to maintain a history of all messages processed.	☐
ESB.16	The ESB will have the ability to ensure that each message is delivered to all the appropriate subscribers.	☐
ESB.17	The ESB will have the ability to verify that each message is only delivered to the appropriate subscribers.	☐

ID	EOHHS Requirement	Bidder Acknowledgment
ESB.18	The ESB will ensure that messages that cannot be delivered will be sent to a location which allows the content of the message to be viewed by an administrator.	☐
ESB.19	The ESB processing engine must be deployed on the application tier of the Web Foundation.	☐
ESB.20	The integration gateway must be deployed on the application tier of the Web Foundation.	☐
ESB.21	The ESB user interfaces may be deployed on the presentation tier of the Web Foundation.	☐
ESB.22	The ESB data services must be deployed on the data tier of the Web Foundation.	☐

O.4 Requirements Checklist for Business Objectives for Enhancements

ID	CMS Checklist	Bidder Acknowledgment
Beneficiary Management Business Area		
CMS.1.	Beneficiary Management Checklist	☐
Care Management Business Area		
CMS.2.	Managed Care Enrollment Checklist	☐
CMS.3.	Managed Care Organization Interfaces Checklist	☐
CMS.4.	Managed Care PIHP and PAHP Checklist	☐
CMS.5.	PCCM and Gatekeeper Managed Care Checklist	☐
CMS.6.	HCBS Waivers Checklist	☐
CMS.7.	Immunization Registry Checklist	☐
CMS.8.	Immunization Registry Owned Checklist	☐
Provider Management Business Area		
CMS.9.	Provider Management Checklist	☐
Operations Management Business Area		
CMS.10.	Reference Data Management Checklist	☐
CMS.11.	Claims Receipt Checklist	☐
CMS.12.	Claims Adjudication Checklist	☐
CMS.13.	Pharmacy Point of Service Checklist	☐
CMS.14.	Third Party Liability Checklist	☐
Program Management Business Area		

ID	CMS Checklist	Bidder Acknowledgment
CMS.15.	Program Management Reporting Checklist	☐
CMS.16.	Federal Reporting Checklist	☐
CMS.17.	Financial Management Checklist	☐
CMS.18.	Decision Support System/Data Warehouse Checklist	☐
CMS.19.	Security and Privacy Checklist	☐
Program Integrity Management Business Area		
CMS.20.	Program Integrity Checklist	☐

O.5 Requirements Checklist for Current MITA Business Processes

ID	MITA Business Area	RI Business Process	Bidder Acknowledgment
MITA.1.	Care Management	Manage Case	☐
MITA.2.	Member Management	Inquire RI Medicaid Member Eligibility	☐
MITA.3.	Member Management	Determine RI Medicaid Eligibility	☐
MITA.4.	Member Management	Manage BCCTP Member Information	☐
MITA.5.	Member Management	Manage RI Medicaid Applicant and Member Communication	☐
MITA.6.	Member Management	Manage RI Medicaid Member Information	☐
MITA.7.	Member Management	Enroll Managed Care Member	☐
MITA.8.	Member Management	Disenroll RI Medicaid Member	☐
MITA.9.	Member Management	Determine Respite Eligibility	☐
MITA.10.	Member Management	Determine BCCTP Eligibility	☐
MITA.11.	Member Management	Manage RI Medicaid Member Grievance and Appeal	☐
MITA.12.	Operations Management	Edit and Audit RI Medicaid Encounter	☐
MITA.13.	Operations Management	Prepare Capitation Premium Payment	☐
MITA.14.	Operations Management	Prepare RI Medicaid Remittance Advice	☐
MITA.15.	Operations Management	Prepare RI Medicaid Provider and Premium EFT	☐
MITA.16.	Operations Management	Prepare REOMB	☐
MITA.17.	Operations Management	Price RI Medicaid Claim	☐

MITA.18.	Operations Management	Edit and Audit RI Medicaid Claim	☐
MITA.19.	Operations Management	Apply Void and Replace	☐
MITA.20.	Operations Management	Apply RI Medicaid Claim Attachment	☐
MITA.21.	Operations Management	Establish Care Plan	☐
MITA.22.	Operations Management	Inquire RI Medicaid Payment Status	☐
MITA.23.	Operations Management	Authorize RI Medicaid Service	☐
MITA.24.	Operations Management	Calculate Medically Needy Spend-Down Amount	☐
MITA.25.	Operations Management	Authorize Personal Choice Waiver Service	☐
MITA.26.	Operations Management	Prepare RIte Care Member Premium Invoice	☐
MITA.27.	Operations Management	Manage RI Medicaid Drug Rebate	☐
MITA.28.	Operations Management	Manage RI Medicaid Estate Recovery	☐
MITA.29.	Operations Management	Manage RI Medicaid Recoupment	☐
MITA.30.	Operations Management	Manage Hospital Cost Settlement	☐
MITA.31.	Operations Management	Manage RI Medicaid TPL Recovery	☐
MITA.32.	Operations Management	Prepare RIte Share Premium Payment	☐
MITA.33.	Program Integrity Management	Identify RI Medicaid Candidate Case	☐
MITA.34.	Program Integrity Management	Manage RI Medicaid Case	☐
MITA.35.	Program Management	Manage Managed Care Rate Setting	☐
MITA.36.	Program Management	Manage 1099s	☐
MITA.37.	Program Management	Manage State Funds	☐

MITA.38.	Program Management	Manage FMAP	☐
MITA.39.	Program Management	Maintain Benefits-Reference Information	☐
MITA.40.	Program Management	Manage RI Medicaid Program Information	☐
MITA.41.	Program Management	Develop and Manage Performance Measures and Reporting	☐
MITA.42.	Program Management	Generate Financial and Program Analysis Report	☐
MITA.43.	Program Management	Develop and Maintain Program Policy	☐
MITA.44.	Program Management	Manage FFP for MMIS	☐
MITA.45.	Program Management	Manage Standard RI Medicaid Rate Setting	☐
MITA.46.	Program Management	Develop and Maintain Benefit Package	☐
MITA.47.	Program Management	Designate Approved Medicaid Service	☐
MITA.48.	Program Management	Designate Approved Drug Formulary	☐
MITA.49.	Program Management	Formulate Budget	☐
MITA.50.	Provider Management	Disenroll RI Medicaid Provider	☐
MITA.51.	Provider Management	Enroll RI Medicaid Provider	☐
MITA.52.	Provider Management	Inquire RI Medicaid Provider Information	☐
MITA.53.	Provider Management	Manage RI Medicaid Provider Information	☐
MITA.54.	Provider Management	Manage RI Medicaid Provider Grievance and Appeal	☐
MITA.55.	Provider Management	Manage RI Provider Communications	☐
MITA.56.	State Specific	Perform Provider Enrollment Certification	☐

O.6 Requirements Checklist for Transition of Current MMIS Technical Capabilities

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TR-1	The Transition MMIS must be hosted in an enterprise data center.	☐			
TR-2	The Transition MMIS must have a system backup plan that supports the current backup/recovery regiment	☐			
TR-3	The Transition MMIS must have a disaster recovery plan that meets the current Recovery Time Objectives and Recovery Point Objectives.	☐			
TR-4	The Transition MMIS must be hosted in a networked environment that provides equivalent or greater processing resources (e.g. CPU and memory) than the Current MMIS.	☐			
TR-5	The Transition MMIS must be hosted in a networked environment that provides equivalent or greater data storage resources than the Current MMIS.	☐			
TR-6	The Transition MMIS must be hosted in a networked environment that provides equivalent or greater network switching resources than the Current MMIS.	☐			
TR-7	The Transition MMIS servers must have operating systems that are the same version as the Current MMIS or a newer version.	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TR-8	The Transition MMIS must be hosted in a networked environment that provides equivalent or greater system performance than the Current MMIS.	☐			
TR-9	The Transition MMIS must provide equivalent or greater system security than the Current MMIS, and at meet the NIST SP 800-53, rev.3 MEDIUM security threshold as designated by FIPS 199.	☐			
TR-10	The Transition MMIS must provide a development environment that allows the Transition MMIS to be maintained and enhanced.	☐			
TR-11	The development environment must include all the software development tools necessary to maintain and enhance the Transition MMIS.	☐			
TR-12	Software development tools for the Transition MMIS must be the same version as the Current MMIS or a newer version as agreed by the State.	☐			
TR-13	Software servers (e.g. Web servers, report servers) for the Transition MMIS must be the same version as the Current MMIS or a newer version.	☐			
TR-14	The Transition MMIS must provide an MMIS test environment for developers.	☐			
TR-15	The Transition MMIS must provide an MMIS test environment for business analysts.	☐			

ID	EOHHS Requirement	Bidder Acknowledgment	Response Code	Bidder Considerations	Proposal Reference
TR-16	The Transition MMIS must provide an MMIS test environment for user acceptance testing.	☐			
TR-17	The Transition MMIS must provide an MMIS production environment.	☐			
TR-18	The Transition MMIS must provide an internet connection with equivalent or greater capacity than the Current MMIS.	☐			
TR-19	The Transition MMIS must support all the business functionality of the Current MMIS.	☐			
TR-20	The Transition MMIS must implement all interfaces between the Current MMIS and external systems.	☐			

O.7 Requirements Checklist for Fiscal Agent Responsibilities

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
	Operations Management Business Area	
<i>OPS.1.0</i>	<i>Claims Processing</i>	
OPS.1.1	Pre-screen paper claims before entering into the system.	☐
OPS.1.2	Return claims not meeting State approved screening criteria to providers.	☐
OPS.1.3	Establish claims control balancing processes.	☐
OPS.1.4	Perform claims reconciliation between claim receipts and batch processing input.	☐
OPS.1.5	Enter data from paper claims into the MMIS claims processing system that are not accepted during scanning.	☐
OPS.1.6	Perform exceptional adjudication of claim edits and audits in accordance with State approved guidelines (e.g., deny, override).	☐
OPS.1.6.1	Resolve suspended claims for all Medical Assistance programs as well as certain medical claims for other agency programs designated by DHS, including BHDDH, DEA, DOC, DOH and DCYF programs (for discussion during JAR sessions).	☐
OPS.1.6.2	Support claims processing for CNOMs, which are non-Medicaid Services that receive Federal Financial Participation (FFP), for those services designated by DHS. Agencies administering the 21 CNOMs include DHS, DEA, DOH, DCYF and BHDDH. A complete list of CNOMs is included in the Bidder's Library.	☐
OPS.1.6.3	Conduct clinical review of suspended claims as necessary.	☐
OPS.1.7	Perform adjudication of claims exceptions within thirty (30) days according to State and Federal billing guidelines.	☐
OPS.1.8	Recommend necessary and desirable edit and audit criteria to accommodate new procedure codes, enhanced claims processing, and the	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
	implementation of new cost containment initiatives.	
OPS.1.9	Identify and monitor operators who are authorized to force or override an edit/audit code based on individual operator IDs or authorization level.	☐
OPS.1.10	Establish controls to ensure that no paper claims and attachments, tapes, or diskettes are misplaced after receipt by the contractor.	☐
OPS.1.11	Operate the system generated claims function of the MMIS.	☐
OPS.1.12	Process all system generated claims and adjustments according to State-defined schedules and policies.	☐
OPS.1.13	Operate the Medicare crossover claims function of the MMIS for all media types.	☐
OPS.1.14	Report to the State any problems related to receipt of automatic crossovers and adjustments (e.g., all electronic crossovers received directly from the Medicare Intermediary or Carrier) that impact the timely processing of claims.	☐
OPS.1.15	Schedule meetings/conferences with State and Medicare contractors when necessary to resolve issues related to receipt or processing of Medicare crossover claims.	☐
OPS.1.16	Operate the claims/encounter pricing function of the MMIS.	☐
OPS.1.17	Manually price certain claims according to State specified criteria within the timeframes defined by the State.	☐
OPS.1.18	Operate the remittance advice function of the MMIS.	☐
OPS.1.18.1	Produce or reproduce Remittance Advices (RAs), in hardcopy or standardized electronic format, in non-technical language that is understandable.	☐
OPS.1.19	Make the 835 transaction information available to providers/vendors.	☐
OPS.1.20	Operate the encounter data system function of the MMIS.	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
OPS.1.21	Provide technical assistance to MCOs as directed by the State on as needed basis.	☐
OPS.1.22	Maintain and update encounter data submission manuals for MCOs.	☐
OPS.1.23	Perform all claim adjustment activities according to GAAP.	☐
OPS.1.24	Retain backup documentation to support mass adjustments.	☐
OPS.1.25	Accommodate all State requests for system-generated adjustments.	☐
OPS.1.26	Process monthly DCYF claims and produces reports showing claimable amounts (claims paid) for Medicaid-eligible services.	☐
<i>OPS.2.0</i>	<i>Prior Authorizations</i>	
OPS.2.1	Operate and maintain the Prior Authorization function within the MMIS.	☐
OPS.2.2	Process requests for authorizations in writing from providers.	☐
OPS.2.3	Provide real-time access via various methods (e.g., Web Portal, AVRS,) for PA status inquiries.	☐
OPS.2.4	Enter and/or accept PA requests, approvals, etc., into the MMIS, online from authorized sources.	☐
OPS.2.5	Assign unique PA control numbers and batches to PAs and accompanying documentation.	☐
OPS.2.6	Generate PA approval and denial notices within two (2) business days of online entry to EOHHS and processing or according to an auto-generation distribution schedule defined by EOHHS.	☐
<i>OPS.3.0</i>	<i>Third Party Liability</i>	
OPS.3.1	Perform Data Matching with health plans to identify unreported health plans, including the following:	☐
OPS.3.1.1	Establishing data match agreements with health plans in accordance with DRA requirements	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
OPS.3.1.2	Schedule and perform data matches on a monthly basis.	☐
OPS.3.1.3	Verifying match results and uploading new completely verified member health insurance information to the member TPL record in the MMIS.	☐
OPS.3.1.4	Triaging all insurance leads in order to identify other members affiliated with the case and to assess the completeness of the insurance information.	☐
OPS.3.2	Understand all current and new CMS regulatory requirements and implement updates/changes to ensure compliance (i.e. Deficit Reduction Act, etc.) with cost avoidance related regulations.	☐
OPS.3.3	Generate and distribute quarterly SWICA letters from a Dept. of Labor (DOL) data match.	☐
OPS.3.4	Generate list of claims paid with a third party payment including Medicare where there is no client TPL and/or Medicare record.	☐
OPS.3.4.1	As needed, contact insurance company to verify coverage information, i.e. policyholder information, type of coverage, dates of coverage, policy number, group number, employer information, benefits manager, dependent coverage, cost sharing obligation, etc. Update insurance information on member TPL record as applicable.	☐
OPS.3.5	Tracking and reporting new lead and verification activities.	☐
OPS.3.6	Generate and distribute member coordination of benefit communications	☐
OPS.3.7	Provide pay and recover activities with third parties (health plans), including the following:	☐
OPS.3.7.1	Identify and bill all pay and recover claims to liable health plans within federally mandated timeframes for retroactive periods authorized under the DRA.	☐
OPS.3.7.2	Generate and distribute written communications to support pay and recover activities.	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
OPS.3.7.3	Understand all current and new CMS regulatory requirements and implement updates/changes to ensure compliance (i.e. Deficit Reduction Act, etc.) Pay and recover related regulations.	☐
OPS.3.8	Track and report on performance of pay and recover activities.	☐
<i>OPS.4.0</i>	<i>Pharmacy Management</i>	
OPS.4.1	Establish and staff POS Pharmacy (Provider) Help Desk.	☐
OPS.4.2	Maintain and implement updates to the Preferred Drug List and State Maximum Allowable Cost (SMAC) pricing files as approved by EOHHS. The Professional Services provided for the PDL include Pharmacy and Therapeutics (P & T) Committee support including:	☐
OPS.4.2.1	Prepare and present therapeutic drug class reviews at committee meetings	☐
OPS.4.2.2	Develop recommendations for preferred drug list inclusion	☐
OPS.4.2.3	Identify clinical program impacts and annual presentation of P & T program impacts.	☐
OPS.4.3	Maintain and implement updates to the drug reference file as approved by EOHHS.	☐
OPS.4.4	Maintain and implement updates to the J-Code/NDC crosswalk as approved by EOHHS.	☐
OPS.4.5	Maintain and update drugs identified by EOHHS for the auto prior authorization process.	☐
OPS.4.6	Provide direct access for the help desk staff to the provider authorization system in order to respond to real-time provider requests.	☐
OPS.4.7	Administer the member lock-in program in accordance with State policies and procedures, including but not limited to the following:	☐
OPS.4.7.1	Review of recipient usage patterns to detect fraud and abuse.	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
OPS.4.7.2	Notify providers and members of their selection as a preferred/assigned lock-in provider and inform them of their responsibilities.	☐
OPS.4.7.3	Receive and maintain documentation from providers for evaluating members for the lock-in program.	☐
OPS.4.7.4	Maintain evidence showing reasons for Lock-in.	☐
OPS.4.7.5	Assign recipient a lock-in restriction to a single prescriber and/or pharmacy.	☐
OPS.4.8	Perform all Drug Utilization Review (DUR) activities in accordance with State policy and procedures.	☐
OPS.5.0	<i>Drug Rebate</i>	
OPS.5.1	Generate and send out drug rebate invoices (including cover letter) for each labeler that has a rebate agreement signed with CMS or the State.	☐
OPS.5.2	Receive and process rebate checks from labelers. Post receivables.	☐
OPS.5.3	Receive, log, and process labeler disputes.	☐
OPS.5.4	Perform dispute resolution, including research discrepancies by reviewing the claim-level detail, and calling Providers as necessary in regards to questionable claims.	☐
OPS.5.5	Maintain the drug rebate data to facilitate automatic updating with information from CMS and EOHHS.	☐
OPS.5.6	Perform direct data entry of all historical data from State sources.	☐
OPS.5.7	Reconcile all data sources to ensure accuracy of invoicing.	☐
OPS.5.8	Maintain and update data on manufacturers with whom rebate agreements exist, including:	☐
OPS.5.8.1	Manufacturer ID numbers and labeler codes	☐
OPS.5.8.2	Indication of collection media	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
OPS.5.8.3	Indication of invoicing media	☐
OPS.5.8.4	Contact name, mailing address, and phone numbers (voice and fax) for manufacturers	☐
OPS.5.8.5	Manufacturer (labeler) enrollment dates and termination dates	☐
OPS.5.9	Generate invoice cover letters, collection letters, and follow-up collection letters according to BMS criteria.	☐
OPS.5.10	Maintain an audit trail of all correspondence, invoices, payments, and adjustments.	☐
OPS.5.11	Generate manufacturer mailing labels on request.	☐
OPS.5.12	Operate the Supplemental Drug Rebate Program which provides inclusion in the National Medicaid Pooling Initiative, submission of supplemental rebates, associated dispute resolution and financial program impacts. All functions performed for the Federal Drug Rebate Program are expected to be performed for the Supplemental Drug Rebate Program, as applicable.	☐
	Program Management Business Area	
<i>PRM.6.0</i>	<i>Finance Management</i>	
PRM.6.1	Render Provider reimbursements promptly and correctly, in accordance with Appendix X (Service Level Agreements), specified contracts, 42 CFR Part 447.45(d) – Payment for Services, and all other requirements in this RFP (including Appendices).	☐
PRM.6.2	Accept and process non-claim financial transactions (FACN) payment requests from EOHHS, at any time during the payment cycle.	☐
PRM.6.3	Process FFS payments on a schedule defined by EOHHS.	☐
PRM.6.4	Process capitation payments to MCO(s) and other Providers on a schedule defined by EOHHS.	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
PRM.6.5	Process requests to withhold/recoup a fixed dollar amount or a percentage of payments for any MCO or Provider from current payments.	☐
PRM.6.6	Support reconciliation process by researching and resolving any discrepancies.	☐
PRM.6.7	Support recoupment/refund functionality	☐
PRM.6.8	Research potential payment errors and take corrective action.	☐
PRM.6.9	Generate and distribute regular payment and refund reports from the MMIS for State monitoring.	☐
PRM.6.10	Generate and distribute regular payment and refund reports from the MMIS for State monitoring.	☐
PRM.6.11	Generate reports of check register and provider account balances after each claims processing cycle for State review.	☐
PRM.6.12	Assure the accuracy of EFTs, data transmission and data reconciliation.	☐
PRM.6.13	Operate and manage the accounts receivable functions in compliance with GAAP.	☐
PRM.6.14	Perform accounts receivable functions as directed by the State to include but not limited to:	☐
PRM.6.14.1	Collect overpayments	☐
PRM.6.14.2	Payments due as the result of audits and peer review findings	☐
PRM.6.14.3	Monies due from the drug rebate program.	☐
PRM.6.14.4	Monies due from pay and recover activities.	☐
PRM.6.15	At minimum, process the following financial transactions:	☐
PRM.6.15.1	Accounts Receivables	☐
PRM.6.15.2	Recoupments	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
PRM.6.15.3	Manual Checks	☐
PRM.6.15.4	Application of checks received to accounts receivable	☐
PRM.6.15.5	Application of checks to a payor's payment history file	☐
PRM.6.15.6	Check Stop Payment and EFT reversals	☐
PRM.6.15.6	Check Voids and void re-issue and EFT reversals	☐
PRM.6.16	Establish and maintain financial processing and adjustment processing policies and procedures and posting instructions.	☐
PRM.6.17	Perform invoicing and payment collection for Rhode Island's Children's Health Account , specific functions include:	☐
PRM.6.17.1	Generate invoices to insurance companies for an amount determined by DHS as per a RI Statute formula. Invoicing is done annually with the exception of two carriers that are done quarterly.	☐
PRM.6.17.2	Receive payments and post payments against the applicable ARs for the invoiced amounts.	☐
PRM.6.17.3	Send second notice invoice if payment is not received. Notify DHS if second notice is not paid.	☐
PRM.6.18	Provide Premium Collection professional services including a customer service team to answer inquiries from recipients on premiums invoiced, payments, coverage status, appeals, etc.	☐
PRM.6.19	Mail the Premium Collection invoices, provide lock-box services and payment processing (including credit card, debit, ACH, cash and Web payment options) and deposit payments to a State Account.	☐
	Track and report Premium Collection Accounts Receivable.	☐
PRM.6.20	Support the following business processes for RIteShare (RS):	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
PRM.6.20.1	Process RS co-payment claims	☐
PRM.6.20.2	Manage RS direct member payment accounts	☐
PRM.6.20.3	Process RS payments and process direct member cost-share deductions	☐
	Generate employer-sponsored insurance premiums to members or employers as directed by EOHHS.	☐
PRM.6.20.4	Report RS detail to EOHHS including deposits, payment totals, exception payments, refunds, not sufficient fund checks, and premiums paid for RS members.	☐
<i>PRM.7.0</i>	<i>Performance Improvement Team</i>	
PRM.7.1	Staff the EOHHS Process Improvement Team which researches potential cost savings solutions and completes other special projects as assigned.	☐
PRM.7.2	Support Program Integrity through preparation and facilitation of multiple, annual CMS, other federal audits, and the SAS70 audit.	☐
<i>PRM.8.0</i>	<i>Quality Assurance</i>	
PRM.8.1	Implement quality assurance measures (self-audits) to ensure consistency and correctness of entered operations management information, achievement of SLAs, and share the information with the State on a monthly basis.	☐
<i>PRM.9.0</i>	<i>Reporting and Data Analysis</i>	
PRM.9.1	Operate the Data Warehouse component of the MMIS. Develop and generate reports defined and on a frequency established by DHS.	☐
PRM.9.2	Provide timely information to support State and Federal program initiatives and reporting requirements.	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
PRM.9.3	Provide uniform cut-off points (dates) for every report to ensure the consistency of all reports.	☐
PRM.9.4	Ensure that changes made to benefit packages and programs, to category of service, provider type and specialty carry through to and across reports and is documented.	☐
	Ensure the accuracy of all reports before delivery to the State.	☐
PRM.9.5	Reconcile and balance MARS report data to comparable data from other MARS reports to ensure internal validity and to non-MARS reports including DSS to ensure external validity, and provide an audit trail. Deliver the balancing report to the State with each MARS production.	☐
PRM.9.6	Notify the State of any imbalances existing in the MARS reports, including the reason for the imbalance upon discovery.	☐
PRM.9.7	Support State staff with inquiries resulting from the balancing procedures. Modify or add balancing procedures, as required by the State.	☐
PRM.9.8	Deliver reports on a variety of media, including online, hard copy, or other electronic media as specified by the state.	☐
PRM.9.9	Modify the MARS reports to ensure compliance with changes in State and Federal reporting regulations, changes to standardized reporting elements and new formats.	☐
PRM.9.10	Provide technical assistance as needed to assist users in researching problems, reviewing production outputs, and understanding report formats.	☐
PRM.9.11	Maintain and distribute up-to-date MARS documentation to designated state users and/or locations.	☐
PRM.9.12	Provide information to support institutional rate setting, capitation fee setting, and/or cost settlements by program.	☐
PRM.9.13	Create new data and data linkages based upon State directives.	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
PRM.9.14	Maintain the DW data dictionary and data relationships of fields and elements. Elements and fields must be defined so that they are understandable for the end user.	☐
PRM.9.15	The DW must maintain data files, as necessary, to meet all Federal and State requirements and to produce Federal reports and State reports.	☐
PRM.9.16	Maintain data warehouse documentation and make it available to the State in a format useful by the State.	☐
PRM.9.17	Support modifications to DW reports currently in production.	☐
PRM.9.18	Support the development of new DW standard and ad-hoc reports as requested by the state.	☐
PRM.9.19	Produce CMS 2082 in Federal and State hard-copy format for verification and DHHS use and in Federal Medicaid Statistical Information System (MSIS) electronic format for submission to CMS.	☐
	Member Management Business Area	
<i>MEM.10.0</i>	<i>Dental Benefits Manager (DBM)</i>	
MEM.10.1	Data enter the DBM member enrollments and dis-enrollments provided by DHS into the MMIS.	☐
<i>MEM.11.0</i>	<i>Managed Care Services</i>	
MEM.11.1	Provide services regarding managed care premium billing and payment, enrollment and disenrollment actions and reinstatement decisions for Rhode Island's managed care programs (see PRM.6.18 through 6.20.4)	☐
MEM.11.2	Maintain current and historical managed care eligibility information in the MMIS based on data from InRhodes and Rite Care/Share systems.	☐
MEM.11.3	Manage disenrollments and reinstatements in managed care programs according to Rhode Island policy. Provide appropriate data to InRhodes regarding disenrollments for non-	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
	payment of premiums.	
MEM.11.4	Provide assistance to State staff in responding to employer and client questions regarding enrollment, disenrollments and premium issuance and collection.	☐
<i>MEM.12.0</i>	<i>Other Member Services</i>	
MEM.12.1	Maintain the Language Web Directory ("Ask Rhody") on the Web in English, Spanish and Portuguese. (Note: The current FA works with the United Way to support maintenance of this directory).	☐
MEM 12.2	Administer the Incentive Card program, including but not limited to the following functions:	☐
MEM 12.2.1	Issue and mail incentive cards to recipients on a weekly basis.	☐
MEM 12.2.2	Coordinate the funding of the account and provide oversight of the data transmission for the production of the incentive cards.	☐
MEM 12.2.3	Forward the data file for incentive payments within three (3) business days of receipt from DHS.	☐
	Provider Management Business Area	
<i>PRV.13.0</i>	<i>Provider Enrollment</i>	
PRV.13.1	Operate and maintain the Provider Management System according to current and future Federal MMIS certification requirements, Part 11 of State Medicaid Manual and according to all State requirements.	☐
PRV.13.2	Operate the provider enrollment and re-enrollment review and approval function of the MMIS.	☐
PRV.13.3	Provide staff knowledgeable in all Federal and State provider enrollment and re-enrollment regulations.	☐
PRV.13.4	Receive and process provider enrollment and re-enrollment information, including reviewing for completeness, obtaining missing information, performing eligibility approval, and	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
	enter approved data into the provider file.	
PRV.13.5	Develop and print, subject to State approval, provider enrollment forms.	☐
PRV.13.6	Distribute hard-copy provider enrollment forms based upon requests from providers.	☐
PRV.13.7	Notify providers of acceptance/rejection as a Medicaid provider and send accepted providers required information for the provision and billing of Medicaid services.	☐
PRV.13.8	Send termination notices to providers.	☐
PRV.13.9	Generate and distribute State and Federal billing guidelines and Medicaid compliance guidelines.	☐
PRV.13.10	Forward provider enrollment appeals along with relevant documentation to the State for review.	☐
PRV.13.11	Assist the State in developing and maintaining detailed guidelines and procedures to ensure proper enrollment and re-enrollment of all provider types.	☐
PRV.13.12	Handle all provider enrollment activities for out of state providers.	☐
PRV.13.13	Maintain and store hard copy and/or electronic copies of provider materials for all approved and denied providers. The file for approved providers must contain the application, provider agreements, copy of provider license, and all correspondence relating to enrollment or re-enrollment resulting in a provider file update. Files for denied providers will include applications and/or profile information and documentation regarding the reason for the denial.	☐
PRV.13.14	Process provider sanctions according to State guidelines.	☐
PRV.13.15	Produce an annual report to ensure compliance with the False Claims Act.	☐
PRV.13.16	Operate and maintain the trading partner enrollment management function of the MMIS.	☐
PRV.13.17	Process provider requests for information and/or TPA forms.	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
PRV.13.18	Process submitted TPAs.	☐
PRV.13.19	Maintain procedures for TPA distribution and collection.	☐
PRV.13.20	Ensure completed TPA is returned by the provider prior to testing electronic data exchange.	☐
PRV.13.21	Annually verify TPA data.	☐
PRV.13.22	Ensure the master provider file has been updated prior to the claims processing cycle.	☐
<i>PRV.14.0</i>	<i>Provider Services Call Center</i>	
PRV.14.1	Maintain and staff a Provider Services Call Center to include toll-free telephone lines that are accessible according to a DHS-approved schedule.	☐
PRV.14.2	Monitor and report call center metrics, such as call abandon rate, call length, hold time, ring busy time, peak hour statistics, and speed of answer, to demonstrate compliance with all applicable SLAs (Appendix J).	☐
PRV.14.3	Respond to an unlimited number of calls per Provider.	☐
PRV.14.4	Provide DHS approved educational scripts for callers on hold or waiting in queue.	☐
PRV.14.5	Review scripts regularly to determine if revisions are necessary and report recommendations to DHS.	☐
PRV.14.6	Document call information as specified by DHS.	☐
PRV.14.7	Monitor, record, and audit calls for quality control, customer service, program integrity, and training purposes. Vendor shall document and retain results on all calls and submit documentation to DHS upon request.	☐
<i>PRV.15.0</i>	<i>Provider Training and Outreach</i>	
PRV.15.1	Develop and submit for State approval the annual provider training and meeting plan. This plan shall include training for State designated organizations and, when	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
	appropriate, personnel from DHS and other departments. The Provider training and meeting plan shall include standard training and other additional needs identified by the State.	
PRV.15.2	Deliver regularly scheduled education for newly certified Medicaid providers and new provider staff about the basic information on the Rhode Island Global Waiver program, including, but not limited to the following:	☐
PRV.15.2.1	Claims processing system	☐
PRV.15.2.2	Proper billing and prior authorization procedures	☐
PRV.15.2.3	Enrollment process	☐
PRV.15.2.4	Communication processes (both manual and electronic)	☐
PRV.15.3	Deliver education training through regular regional workshops, training sessions, and presentations at professional association meetings.	☐
PRV.15.4	Develop and distribute surveys to providers soliciting their feedback regarding available training, services provided, service levels, programs, processes, procedures, and ideas for improvement.	☐
PRV.15.5	Provide training ad-hoc sessions based on requests from the State.	☐
PRV.15.6	Deliver special in-depth training to providers, who have been identified (by the vendor, by the State, or by the provider's association) with certain problem characteristics, including, but not limited to, the following:	☐
PRV.15.6.1	Abnormal number of claims denied or suspended	☐
PRV.15.6.2	Abnormal number of problems with the prior authorization process (e.g., high number of errors, modifications, returns, or denials)	☐
PRV.15.6.3	Repeated problems with enrollment or re-enrollment	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
PRV.15.6.4	Abnormal number of problems using the contractor's system.	☐
	Care Management Business Area	
<i>CRM.16.0</i>	<i>Radiology Management</i>	
CRM.16.1	Perform Radiology Management services including Prior Authorization (PA) for radiology services.	☐
CRM.16.2	Review requests along with history in the MMIS to ensure medical necessity and a prior auth or denial that is consistent with clinical guidelines and state policy on radiology procedures.	☐
CRM.16.3	Send approvals electronically to the MMIS to support claims processing.	☐
CRM.16.4	Generate reports on the PA processing and results and provide to EOHHS on a monthly and quarterly basis.	☐
CRM.16.5	Provider helpdesk must support calls from providers on radiology management.	☐
<i>CRM 17.0</i>	<i>Professional Clinical Services</i>	
CRM.17.1	Provide two (2) Dental Consultants credentialed with a dental specialty of orthodontics. These dental consultants are responsible for reviewing prior authorization requests for orthodontic services.	☐
CRM.17.2	Provide two (2) Clinical Consultants trained as psychologists, one (1) trained as a physical therapist and one (1) trained as an occupational therapist. The staff is located at the DHS facility and uses DHS assets including workstations, phones, and other office equipment as DHS supplies its own employees at no cost to the Fiscal Agent.	☐
	Surveillance Utilization and Review (SURS) Business Area	
SUR.18.1	Operate and maintain the SURS Management system according to current and future Federal MMIS certification requirements, Part 11 of the State Medicaid Manual, and according to all	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
	State requirements.	
SUR.18.2	Operate the Data Matches function within the MMIS Program Integrity business area.	☐
SUR.18.3	Perform activities to proficiently and proactively detect:	☐
SUR.18.3.2	Potential fraud, abuse or misuse by all providers and members	☐
SUR.18.3.3	Inappropriate billings and over payments, and violations by providers	☐
SUR.18.3.4	Significant percentage increase or decrease in provider's claims	☐
SUR.18.4	Notify State if potential fraud is suspected or reported by the recipient.	☐
SUR.18.5	Receive and take action on correspondence received from the State.	☐
SUR.18.6	Create and perform other provider audit profiles as directed by the State.	☐
SUR.18.7	Provide staff to support provider audit applications and conduct field audits as necessary.	☐
SUR.18.8	Schedule for the SUR run to coincide with the Federal Fiscal Year.	☐
SUR.18.9	The FA vendor will produce the scheduled SUR reports and inform DHS of their availability.	☐
SUR.18.10	Initiate and follow up on provider or member reviews as directed by the State when information is received through the following:	☐
SUR.18.10.1	SUR reporting exceptions, or profiles	☐
SUR.18.10.2	Complaints	☐
SUR.18.10.3	Referrals from State and Federal agencies	☐
SUR.18.10.4	Referrals from health care providers	☐
SUR.18.10.5	Global cases – national cases involving numerous parties, such as states, the Department of Justice or Medicaid Fraud Control Units	☐

ID	Fiscal Agent Responsibilities	Bidder's Acknowledgment
SUR.18.10.6	Explanation of Benefits (EOB)	☐
SUR.18.11	Record cases selected for review in the provider or member case tracking management tool.	☐
SUR.18.12	Record complaints and non-formal referrals in the provider case tracking management tool.	☐

Appendix P: Medicaid Enterprise Certification Checklists

The following checklists support the high-level requirements for enhancements to claims processing functions in the current MMIS. The high-level MMIS requirements are organized to align with the Medicaid Enterprise Certification Toolkit Checklists issued September 28, 2007 by CMS. State-Specific Business Objectives are highlighted and uniquely numbered with the Checklist Item Initial followed by “SS” to indicate State-Specific checklist item, then numerically sequenced 1, 2, 3 etc.

The following checklists are included:

- Claims Receipt
- Reference Data Management
- Claims Adjudication
- Pharmacy Point-of-Sale
- Provider Management
- Beneficiary Management
- Managed Care Enrollment
- Managed Care Organization Interfaces
- Managed Care Prepaid Inpatient Health Plan and Prepaid Ambulatory Health Plan
- PCCM and Gatekeeper Managed Care
- Decision Support System/Data Warehouse
- Federal Reporting
- Program Management Reporting
- Financial Management
- Security and Privacy
- Third Party Liability
- HCBS Waiver
- Program Integrity
- Operations Management

Claims Receipt

MITA Business Process Area: Operations Management

Table 41: Claims Receipt Requirements

Reference #	Business Objective
CR1	Accept claims and other transactions electronically and via hard copy.
CR2	Accept attachments and other materials related to claims and other transactions as required for review and approval.
CR3	Comply with HIPAA requirements. • Implement ANSI X12 5010 HIPAA transactions
CRSS1	Implement electronic attachment functionality in compliance with State and national standards.
CRSS2	Eliminate or reduce manual, paper claims receipt and adjudication processes.
CRSS3	Require State-specified standard forms for all paper claims.

Reference Data Management

MITA Business Process Area: Operations Management

Table 42: Reference Data Management Requirements

Reference #	Business Objective
RF1	Manage reference data to support claims processing, data to consist of proper procedure, diagnosis, formulary and drug pricing codes, charge information, and data that supports different payment methods (e.g. Outpatient Prospective Payment System (OPPS), Diagnosis Related Group (DRG), etc), and other items as needed by the State.
RF2	Comply with Health Insurance Portability and Accountability Act (HIPAA) requirements. • Support the use of the ICD-10 code set • Require national Medical Data Code Sets (e.g., HCPCS codes or CPT codes) on all claims
RFSS1	Increase automation of non-managed care rate setting through: • Automation of standards (processes and data content) • Online, immediate access for authorized users

Claims Adjudication

MITA Business Process Area: Operations Management

Table 43: Claims Adjudication Requirements

Reference #	Business Objective
CA1	Route claims for processing and track claim progress, status, and location.
CA2	Process claim data against defined service, policy, and payment parameters.
CA3	Validate that claims are from properly enrolled and eligible providers.
CA4	Validate that claims are for eligible Beneficiaries.
CA5	Provide for the timely disposition of prior authorization requests.
CASS1	Adjudicate claims for all Medical Assistance programs as well as certain medical claims for other agency programs designated by DHS, including BHDDH, DEA, DOC, DOH and DCYF programs.
CASS2	Support claims processing for CNOMs, which are non-Medicaid Services that receive Federal Financial Participation (FFP), for those services designated by DHS. Agencies administering CNOMs include DHS, DEA, DOH, DCYF and BHDDH.
CASS3	Reduce health services claims-related lump sum and FACN off-line transactions designated by DHS.
CASS4	Require the use of rendering providers on claims for programs and waivers designated by DHS, according to national billing standards.
CASS5	Implement electronic prior authorizations ANSI X12 5010 278 transactions.
CASS6	Update program edits, and pended and denied claims procedures based on agency-specific review of policies (DHS, DEA, BHDDH, DOH, DCYF and DOC).
CASS7	Process Medicare premium payments through the MMIS.
CASS8	Adjudicate nursing home claims according based on Resource Utilization Groups.
CASS9	Implement and provide ongoing support for consistent claims adjudication processes for every State-funded purchase processed through the MMIS, allowing variations in reimbursement, edits and authorizations by agency.
CASS10	Implement and maintain edits and rules to support the requirements of the Affordable Care Act to achieve compliance deadlines.

Pharmacy Point of Service (POS)

MITA Business Process Areas: Program Management, Operations Management

Table 44: Pharmacy Point of Service (POS) Requirements

Reference #	Business Objective
POS1	Maintain interfaces between the POS system and comprehensive, accurate, and up-to-date data sources required to approve and adjudicate claims according to State and Federal rules. Maintain interfaces between POS and reporting applications, e.g., Federal reporting, data warehouse/decision support, drug manufacturer rebate invoicing, program integrity, and others.
POS2	Ensure timely and accurate adjudication of provider claims.
POS3	Verify authorization for services that require prior approval in order to manage costs or ensure patient safety.
POS4	Verify that services are medically appropriate, conform to Federal and State policies, and result in the maintenance or improvement of patient health.
POS5	Deny claims for members with third party coverage, including Part D Medicare, or flag for pay-and-chase activity.
POS6	Support other business processes that require pharmacy claims data, e.g., rebate invoicing, retrospective DUR, and decision support.
POSSS1	Support pharmacy claims processing for enterprise-wide processing for current DHS, DOH (ADAP) and BHDDH (CMAP).
POSSS2	Support Pharmacy POS subrogation according to the current standard.

Provider Management

MITA Business Process Areas: Operations Management, Provider Management

Table 45: Provider Management Requirements

Reference #	Business Objective
PR1	Enroll and maintain adequate provider network for the Medicaid Beneficiary population.
PR2	Ensure quality of provider network and accuracy of payment arrangement.
PR3	Maintain provider information.
PR4	Comply with Health Insurance Portability and Accountability Act (HIPAA) requirements. Require that only the NPI be used on all transactions (applications, claims, prior authorizations, etc.)
PRSS1	Enhance the MMIS to enroll and maintain data for all providers for those programs designated by DHS, including transportation (taxis and RIDE vans), Respite Waiver, Shared Living, Personal Choice, Early Intervention, Breast and Cervical Cancer Screening, DCYF and CNOM providers.

Reference #	Business Objective
PRSS2	Automate verification steps of Provider Enrollment process including: • Validation of NPI • State and federal sanction look-ups • Development of an automated interface with DOH to perform real-time license checks
PRSS3	Enhance the provider Web portal to electronic submittal of claims with attachments and prior authorizations.

Beneficiary Management Business Objectives

MITA Business Process Areas: Member Management, Operations Management

Table 46: Beneficiary Management Requirements

Reference #	Business Objective
BE1	Collect and manage information about the Beneficiary population from diverse sources.
BE2	Maintain information on each Beneficiary's Medicaid benefits to support claims payment and other financial processes.
BE3	Allow verification of Beneficiary Medicaid eligibility information by external entities.
BE4	Comply with HIPAA requirements.
BE5	Manage the Medicare Buy-In and Part D data exchange processes (optionally supported by MMIS).
BESS1	Maintain client eligibility data for all medical programs designated by DHS, including State Medical Assistance and Global Waiver programs, CNOMs, DEA, DCYF and BHDDH medical programs, DOC medical claims, and pharmacy point-of-sale programs for DHS, DEA, BHDDH and DOH. This also includes maintenance of client data for transportation, Early Intervention, Respite Waivers, Breast and Cervical Cancer programs (to be detailed during JAR sessions).
BESS2	Automate the tracking of patient liability through the MMIS for clients participating in specified programs or waivers, including receipt and maintenance of data from the eligibility system of record and offset of liability as reported on submitted claims (for discussion during JAR sessions).
BESS3	Implement and support functionality to meet the requirements of the Affordable Care Act (ACA) and achieve compliance deadlines.
BESS4	Implement and support an interface and functionality for the MMIS to interact with the Health Insurance Exchange and Health Information Exchange.

Managed Care Enrollment

MITA Business Process Areas: Operations Management, Member Management

Table 47: Managed Care Enrollment Requirements

Reference #	Business Objective
ME1	Process accurate and timely automatic or choice-based enrollment, re-enrollment, and disenrollment of Medicaid eligibles into an MCO, Primary Care Case Manager (PCCM) or Primary Care Physician (PCP) program, including into a Health Maintenance Organization (HMO). Through an interface with the eligibility system of record
ME2	Support data exchange between stakeholders using standard data formats.
ME3	Manage premium collections from Beneficiaries. Through an interface with the eligibility system of record
ME4	Maintain the privacy and security of enrollment information in transit and at rest.
MESS1	Adopt HIPAA standards for all MCO data and interfaces.
MESS2	Maintain primary care physician information in the MMIS.

Managed Care Organization Interfaces

MITA Business Process Areas: Program Management, Operations Management, Member Management

Table 48: Managed Care Organization Interfaces Requirements

Reference #	Business Objective
MC1	Support assessment of members' access to services.
MC2	Make accurate payment to MCO for managed care services provided to enrolled members.
MC3	Receive, process, and store MCO encounter records for use by the Medicaid agency in managing MCO performance.
MC4	Provide information to support assessing quality and cost of care provided to enrollees.
MC5	Identify services covered under capitation premiums and block duplicate fee-for-service payments and supplemental payments to providers.
MC6	Collect and report on financial data related to Medicaid managed care programs.
MC7	Collect data and provide reporting to support MCO contractor monitoring.
MC8	Support specific functions, as applicable, related to the administration of Section 1115 Waivers.

Reference #	Business Objective
MCSS1	Improve encounter data quality through modification of MMIS encounter processing: • Adopt HIPAA standards for all MCO data and interfaces • Process adjustments of encounter data • Make the NPI the identifier of record for encounter data
MCSS2	Review the frequency of interfaces with managed care organizations, and implement new standards.
MCSS3	Design standard reports based on encounter data.
MCSS4	Implement and support care management functionality as described in WASS1.

PCCM and Gatekeeper Managed Care

MITA Business Process Areas: Care Management, Program Management, Operations Management, Member Management

Table 49: PCCM and Gatekeeper Managed Care Requirements

Reference #	Business Objective
MG1	Support enrollment of Medicaid eligibles into PCCM or Gatekeeper program.
MG2	Increase Beneficiary access to care and qualified PCCM providers.
MG3	Process accurate and timely payment to PCCM for gatekeeper services
MG4	Make accurate and timely payments to providers.
MG5	Generate reports to monitor quality and cost of care provided to enrollees.
MGSS1	Implement and support care management functionality as described in WASS1.

Managed Care Prepaid Inpatient Health Plan and Prepaid Ambulatory Health Plan

MITA Business Process Areas: Care Management, Program Management, Operations Management, Member Management

Table 50: Managed Care Prepaid Inpatient Health Plan and Prepaid Ambulatory Health Plan

Reference #	Business Objective
MP1	Support accurate and timely automatic or choice-based enrollment of Medicaid eligibles into a PIHP and PAHP.
MP2	Monitor access to and availability of qualified providers to serve participants enrolled in PIHP and PAHP.
MP3	Make accurate and timely payment to providers for managed care services provided.
MPSS1	Implement and support care management functionality as described in WASS1.

Decision Support System / Data Warehouse

MITA Business Process Area: Program Management

Table 51: Decision Support System/Data Warehouse Requirements

Reference #	Business Objective
DSS1	Support better understanding and management of the Medicaid program by collecting and organizing Medicaid-related data and making this data available in a timely and effective manner.
DSS2	Provide timely and effective reports for management planning and control.
DSS3	Support improved analysis for decision making.
DSSSS1	Maintain and support the input of data and user interface with the EOHHS Data Warehouse to support reporting and decision support.
DSSSS2	Update the Data Warehouse interfaces and incorporate additional decision support requirements.

Federal Reporting

MITA Business Process Area: Program Management

Table 52: Federal Reporting Requirements

Reference #	Business Objective
FR1	Create and submit to CMS the Federally required MSIS reports.
FR2	Create and submit to CMS the Federally required EPSDT reports.
FR3	Create and submit to CMS the Federally required HCBS Waiver reports.
FR4	Meet all other Federal Reporting Requirements.

Reference #	Business Objective
FRSS1	Automate extraction of MMIS, other DHS systems' data and other agency systems' data to support automation of the CMS 64, including: • Functionality to input and track designated FACN transactions and other transactions currently not entered into the MMIS • Automated reporting of those CNOMs designated by DHS
FRSS2	Incorporate automated reporting of the Global Waiver programs designated by DHS to support federal claiming through the MMIS.

Program Management Reporting

MITA Business Process Area: Program Management

Table 53: Program Management Reporting Requirements

Reference #	Business Objective
PM1	Analyze Medicaid program costs and trends to predict impact of policy changes on programs.
PM2	Monitor payment processes and predict trends. • Support caseload reporting, service utilization and other trend analysis
PM3	Analyze provider performance to show extent of participation and service delivery.
PM4	Analyze Beneficiary enrollment, participation, and program usage to predict utilization trends. • Support caseload reporting, service utilization and other trend analysis
PM5	Maintain an efficient and effective management reporting process.
PMSS1	Develop and produce standard reports to support the analysis of DHS and other agency medical programs, including fee for service, CNOM and Global Waiver programs.
PMSS2	Develop standard reports to measure progress against agency goals, initiatives and policy changes.
PMSS3	Automate reports to support caseload reporting and other legislative and program management requirements.
PMSS4	Implement an interface and functionality to support Health Information Exchange reporting.

Financial Management

MITA Business Process Areas: Program Management, Operations Management

Table 54: Financial Management Requirements

Reference #	Business Objective
FI1	Produce Individual Explanation of Benefits (EOB).
FI2	Ensure that accounts payable and receivable transactions are recognized and posted in accordance with State and Federal regulations.
FI3	Ensure that all financial transactions related to program delivery are processed as defined by State and Federal regulations.
FI4	Support management of program funds.
FISS1	Streamline the crosswalk between the MMIS and the State financial system (RIFANS) budget categories.
FISS2	Implement an automated financial Medical Assistance budget forecasting model.
FISS3	Build the capacity to produce standard financial management reports and/or a dashboard on a weekly, monthly, quarterly and annual basis.
FISS4	Build the capacity to produce standard MMIS operations management reports and/or a dashboard on a weekly, monthly, quarterly and annual basis.
FISS5	Implement functionality to support medical homes management, including: • Real-time access to Care Management data • Unique rate-setting options, including: ▪ Flexibility to handle numerous global or episodic reimbursement methodologies ▪ Flexibility to handle multiple pay-for-performance options

Security and Privacy

Table 55: Security and Privacy Requirements

Reference #	Business Objective
SP1	Control access to system and data.
SP2	Protect the confidentiality and integrity of electronic Protected Health Information (ePHI).
SP3	Monitor system activity and act on security incidents.
SP4	Support individual rights specified in the HIPAA Privacy regulations.
SPSS1	Maintain and enforce protocols for access to MMIS data and EOHHS Data Warehouse, including client, provider and Care Management data, for users at DHS and other agencies within the State.

HCBS Waiver

MITA Business Process Areas: Care Management, Program Management, Operations Management, Provider Management

Table 56: HCBS Waiver Requirements (Note: Rhode Island is operating under an 1115 Waiver that encompasses and replaces previous HCBS (1915(c) waivers.)

Reference #	Business Objective
WA1	Control enrollment of participants into the HCBS (1915(c)) waiver programs to meet the State's objectives. (Note: Rhode Island is operating under an 1115 Waiver.)
WA2	Enroll traditional and nontraditional service providers meeting identified standards of care into the program to provide services to the target population.
WA3	Provide services as described in the individual's approved plan of care.
WA4	Process waiver provider claims and make timely and accurate payments.
WA5	Produce program data necessary to satisfy Federal Medicaid reporting requirements, monitor utilization, and assess quality of care provided to participants.
WASS1	Implement an enterprise-wide care management system for all state programs and waivers, as designated by DHS, that provides the following functionality: • Supports primary care case management • Support automated interfaces with Care Management providers/agencies to maintain care plans • Provides a vehicle for claims to edit against authorized care plan services • Update the Care Management system with adjudicated claims data • Supports the exchange of clinical data • Provide security protocols for access to and maintenance of Care Management data as directed by the State • Allow for the creation of customized functional and clinical assessments without the use of programmers • Provide the ability to do authorizations • Supports queries to include targeted information from various systems • Support establishment of patient-centered medical homes, including family care, within client cases
WASS2	Support processing and reporting requirements specific to Rhode Island's Global Waiver approved by CMS.

Third Party Liability

MITA Business Process Area: Operations Management

Table 57: Third Party Liability Requirements

Reference #	Business Objective
TP1	Provide efficient and timely identification and maintenance of Third Party Liability (TPL) resources.
TP2	Obtain the maximum cost avoidance and reimbursement for Medicaid Beneficiaries covered by other insurance.
TPSS1	Provide automatic updates of verified TPL information via interface to the eligibility system of record.
TPSS2	Support an interface to transmit TPL information to and from the Welligent system for Early Intervention program and other system interfaces providing relevant TPL data.
TPSS3	Implement functionality to apply cost recoveries at the individual claim-level, as a single adjustment or mass adjustment.
TPSS4	Automatically process Medicare Part A, B, and C crossover claims and adjustments.
TPSS5	Provide the storage and retrieval of casualty-related information (e.g., motor vehicle accident and workers' compensation information), including automation of interfaces with DMV and DLT.
TPSS6	Automate identification, tracking and follow-up notifications for claims with trauma diagnosis codes, accident codes and indicators.
TPSS7	Provide an automated case tracking tool for Casualty and Estate Recovery activities allowing online access by specified users.

Program Integrity

MITA Business Process Area: Program Integrity Management

Table 58: Program Integrity Requirements

Reference #	Business Objective
PI1	Improve delivery of health care services and the integrity of the Medicaid program by reducing waste, fraud, and abuse through analysis of provider performance.
PI2	Improve delivery of health care services and the integrity of the Medicaid program by reducing waste, fraud, and abuse through analysis of Beneficiary utilization.
PI3	Support analysis of and provide reports for fraud and abuse analysis and investigations.
PI4	Identify and analyze program trends and directions in provider, Beneficiary, and service utilization and expenditure patterns.
PISS1	Develop an integrated case tracking tool for SURS and other program integrity

Reference #	Business Objective
	data that includes standard queries and automated alerts.
PISS2	Establish online access to case data by data-sharing partners.

Operations Management

MITA Business Process Areas: Provider Management, Operations Management, Member Management

Table 59: Provider Call Center Requirements

Reference #	Business Objective
1	Implement improved Provider Call Center functionality through implementation of call distribution and tracking software.