Medicaid Management Information System/Decision Support System/Fiscal Agent Services Procurement

Request for Proposal

March 3, 2005

Jeb Bush
Governor

Alan Levine
Secretary
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http://ahca.myflorida.com/

State of Florida
PUR 1001
General Instructions to Respondents

Contents

1. Definitions. The definitions found in s. 60A-1.001, F.A.C. shall apply to this agreement. The following additional terms are also defined:

(a) "Buyer" means the entity that has released the solicitation.
(b) "Procurement Officer" means the Buyer's contracting personnel, as identified in the Introductory Materials.
(c) "Respondent" means the entity that submits materials to the Buyer in accordance with these Instructions.
(d) "Response" means the material submitted by the respondent in answering the solicitation.
(e) "Timeline" means the list of critical dates and actions included in the Introductory Materials.

2. General Instructions. Potential respondents to the solicitation are encouraged to carefully review all the materials contained herein and prepare responses accordingly.

3. Electronic Submission of Responses. Respondents are required to submit responses electronically. For this purpose, all references herein to signatures, signing requirements, or other required acknowledgments hereby include electronic signature by means of clicking the "Submit Response" button (or other similar symbol or process) attached to or

logically associated with the response created by the respondent within MyFloridaMarketPlace. The respondent agrees that the action of electronically submitting its response constitutes:

- an electronic signature on the response, generally,
- an electronic signature on any form or section specifically calling for a signature, and
- an affirmative agreement to any statement contained in the solicitation that requires a definite confirmation or acknowledgement.

4. Terms and Conditions. All responses are subject to the terms of the following sections of this solicitation, which, in case of conflict, shall have the order of precedence listed:

- Technical Specifications,
- Special Conditions,
- Instructions to Respondents (PUR 1001),
- General Conditions (PUR 1000), and
- Introductory Materials.

The Buyer objects to and shall not consider any additional terms or conditions submitted by a respondent, including any appearing in documents attached as part of a respondent's response. In submitting its response, a respondent agrees that any additional terms or conditions, whether submitted intentionally or inadvertently, shall have no force or effect. Failure to comply with terms and conditions, including those specifying information that must be submitted with a response, shall be grounds for rejecting a response.

5. Questions. Respondents shall address all questions regarding this solicitation to the Procurement Officer. Questions must be submitted via the Q&A Board within MyFloridaMarketPlace and must be RECEIVED NO LATER THAN the time and date reflected on the Timeline. Questions shall be answered in accordance with the Timeline. All questions submitted shall be published and answered in a manner that all respondents will be able to view. Respondents shall not contact any other employee of the Buyer or the State for information with respect to this solicitation. Each respondent is responsible for monitoring the MyFloridaMarketPlace site for new or changing information. The Buyer shall not be bound by any verbal information or by any written information that is not contained within the solicitation documents or formally noticed and issued by the Buyer's contracting personnel. Questions to the Procurement Officer or to any Buyer personnel shall not constitute formal protest of the specifications or of the solicitation, a process addressed in paragraph 19 of these Instructions.

6. Conflict of Interest. This solicitation is subject to chapter 112 of the Florida Statutes. Respondents shall disclose with their response the name of any officer, director, employee or other agent who is also an employee of the State. Respondents shall also disclose the name of any State employee who owns, directly or indirectly, an interest of five percent (5%) or more in the respondent or its affiliates.

7. Convicted Vendors. A person or affiliate placed on the convicted vendor list following a conviction for a public entity crime is prohibited from doing any of the following for a period of 36 months from the date of being placed on the convicted vendor list:

- submitting a bid on a contract to provide any goods or services to a public entity;
- submitting a bid on a contract with a public entity for the construction or repair of a public building or public work;
- submitting bids on leases of real property to a public entity;
- being awarded or performing work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and
- transacting business with any public entity in excess of the Category Two threshold amount ($25,000) provided in section 287.017 of the Florida Statutes.

8. Discriminatory Vendors. An entity or affiliate placed on the discriminatory vendor list pursuant to section 287.134 of the Florida Statutes may not:

- submit a bid on a contract to provide any goods or services to a public entity;
- submit a bid on a contract with a public entity for the construction or repair of a public building or public work;
- submit bids on leases of real property to a public entity;
- be awarded or perform work as a contractor, supplier, sub-contractor, or consultant under a contract with any public entity; or
- transact business with any public entity.

9. Respondent's Representation and Authorization. In submitting a response, each respondent understands, represents, and acknowledges the following (if the respondent cannot so certify to any of following, the respondent shall submit with its response a written explanation of why it cannot do so).

- The respondent is not currently under suspension or debarment by the State or any other governmental authority.
- To the best of the knowledge of the person signing the response, the respondent, its affiliates, subsidiaries, directors, officers, and employees are not currently under investigation by any governmental authority and have not in the last ten (10) years been convicted or found liable for any act prohibited by law in any jurisdiction, involving conspiracy or collusion with respect to bidding on any public contract.
- To the best of the knowledge of the person signing the response, the respondent has no delinquent obligations to the State, including a claim by the State for liquidated damages under any other contract.
- The submission is made in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person to submit a complementary or other noncompetitive response.
- The prices and amounts have been arrived at independently and without consultation, communication, or agreement with any other respondent or potential respondent; neither the prices nor amounts, actual or approximate, have been

disclosed to any respondent or potential respondent, and they will not be disclosed before the solicitation opening.

- The respondent has fully informed the Buyer in writing of all convictions of the firm, its affiliates (as defined in section 287.133(1)(a) of the Florida Statutes), and all directors, officers, and employees of the firm and its affiliates for violation of state or federal antitrust laws with respect to a public contract for violation of any state or federal law involving fraud, bribery, collusion, conspiracy or material misrepresentation with respect to a public contract. This includes disclosure of the names of current employees who were convicted of contract crimes while in the employ of another company.
- Neither the respondent nor any person associated with it in the capacity of owner, partner, director, officer, principal, investigator, project director, manager, auditor, or position involving the administration of federal funds:
  - Has within the preceding three years been convicted of or had a civil judgment rendered against them or is presently indicted for or otherwise criminally or civilly charged for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a federal, state, or local government transaction or public contract; 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; or
  - Has within a three-year period preceding this certification had one or more federal, state, or local government contracts terminated for cause or default.
- The product offered by the respondent will conform to the specifications without exception.
- The respondent has read and understands the Contract terms and conditions, and the submission is made in conformance with those terms and conditions.
- If an award is made to the respondent, the respondent agrees that it intends to be legally bound to the Contract that is formed with the State.
- The respondent has made a diligent inquiry of its employees and agents responsible for preparing, approving, or submitting the response, and has been advised by each of them that he or she has not participated in any communication, consultation, discussion, agreement, collusion, act or other conduct inconsistent with any of the statements and representations made in the response.
- The respondent shall indemnify, defend, and hold harmless the Buyer and its employees against any cost, damage, or expense which may be incurred or be caused by any error in the respondent's preparation of its bid.
- All information provided by, and representations made by, the respondent are material and important and will be relied upon by the Buyer in awarding the Contract. Any misstatement shall be treated as fraudulent concealment from the Buyer of the true facts relating to submission of the bid. A misrepresentation shall be punishable under law, including, but not limited to, Chapter 817 of the Florida Statutes.

10. Performance Qualifications. The Buyer reserves the right to investigate or inspect at any time whether the product, qualifications, or facilities offered by respondent meet

the Contract requirements. Respondent shall at all times during the Contract term remain responsive and responsible. Respondent must be prepared, if requested by the Buyer, to present evidence of experience, ability, and financial standing, as well as a statement as to plant, machinery, and capacity of the respondent for the production, distribution, and servicing of the product bid. If the Buyer determines that the conditions of the solicitation documents are not complied with, or that the product proposed to be furnished does not meet the specified requirements, or that the qualifications, financial standing, or facilities are not satisfactory, or that performance is untimely, the Buyer may reject the response or terminate the Contract. Respondent may be disqualified from receiving awards if respondent, or anyone in respondent's employment, has previously failed to perform satisfactorily in connection with public bidding or contracts. This paragraph shall not mean or imply that it is obligatory upon the Buyer to make an investigation either before or after award of the Contract, but should the Buyer elect to do so, respondent is not relieved from fulfilling all Contract requirements.

11. Public Opening. Responses shall be opened on the date and at the location indicated on the Timeline. Respondents may, but are not required to, attend. The Buyer may choose not to announce prices or release other materials pursuant to s. 119.07(6)(m), Florida Statutes. Any person requiring a special accommodation because of a disability should contact the Procurement Officer at least five (5) workdays prior to the solicitation opening. If you are hearing or speech impaired, please contact the Buyer by using the Florida Relay Service at (800) 955-8771 (TDD).

12. Electronic Posting of Notice of Intended Award. Based on the evaluation, on the date indicated on the Timeline the Buyer shall electronically post a notice of intended award at http://fcn.state.fl.us/owa_vbs/owa/vbs_www.main_menu. If the notice of award is delayed, in lieu of posting the notice of intended award the Buyer shall post a notice of the delay and a revised date for posting the notice of intended award. Any person who is adversely affected by the decision shall file with the Buyer a notice of protest within 72 hours after the electronic posting. The Buyer shall not provide tabulations or notices of award by telephone.

13. Firm Response. The Buyer may make an award within sixty (60) days after the date of the opening, during which period responses shall remain firm and shall not be withdrawn. If award is not made within sixty (60) days, the response shall remain firm until either the Buyer awards the Contract or the Buyer receives from the respondent written notice that the response is withdrawn. Any response that expresses a shorter duration may, in the Buyer's sole discretion, be accepted or rejected.

14. Clarifications/Revisions. Before award, the Buyer reserves the right to seek clarifications or request any information deemed necessary for proper evaluation of submissions from all respondents deemed eligible for Contract award. Failure to provide requested information may result in rejection of the response.

15. Minor Irregularities/Right to Reject. The Buyer reserves the right to accept or reject any and all bids, or separable portions thereof, and to waive any minor irregularity,

technicality, or omission if the Buyer determines that doing so will serve the State's best interests. The Buyer may reject any response not submitted in the manner specified by the solicitation documents.

16. Contract Formation. The Buyer shall issue a notice of award, if any, to successful respondent(s), however, no contract shall be formed between respondent and the Buyer until the Buyer signs the Contract. The Buyer shall not be liable for any costs incurred by a respondent in preparing or producing its response or for any work performed before the Contract is effective.

17. Contract Overlap. Respondents shall identify any products covered by this solicitation that they are currently authorized to furnish under any state term contract. By entering into the Contract, a Contractor authorizes the Buyer to eliminate duplication between agreements in the manner the Buyer deems to be in its best interest.

18. Public Records. Article 1, section 24, Florida Constitution, guarantees every person access to all public records, and Section 119.011, Florida Statutes, provides a broad definition of public record. As such, all responses to a competitive solicitation are public records unless exempt by law. Any respondent claiming that its response contains information that is exempt from the public records law shall clearly segregate and mark that information and provide the specific statutory citation for such exemption.

19. Protests. Any protest concerning this solicitation shall be made in accordance with sections 120.57(3) and 287.042(2) of the Florida Statutes and chapter 28-110 of the Florida Administrative Code. Questions to the Procurement Officer shall not constitute formal notice of a protest. It is the Buyer's intent to ensure that specifications are written to obtain the best value for the State and that specifications are written to ensure competitiveness, fairness, necessity and reasonableness in the solicitation process.

Section 120.57(3)(b), F.S. and Section 28-110.003, Fla. Admin. Code require that a notice of protest of the solicitation documents shall be made within seventy-two hours after the posting of the solicitation.

Section 120.57(3)(a), F.S. requires the following statement to be included in the solicitation: "Failure to file a protest within the time prescribed in section 120.57(3), Florida Statutes, shall constitute a waiver of proceedings under Chapter 120, Florida Statutes."

Section 28-110.005, Fla. Admin. Code requires the following statement to be included in the solicitation: "Failure to file a protest within the time prescribed in Section 120.57(3), Florida Statutes, or failure to post the bond or other security required by law within the time allowed for filing a bond shall constitute a waiver of proceedings under Chapter 120, Florida Statutes."

State of Florida
PUR 1000
General Contract Conditions

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41. Modification of Terms.
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1. Definitions. The definitions contained in s. 60A-1.001, F.A.C. shall apply to this agreement. The following additional terms are also defined:

(a) "Contract" means the legally enforceable agreement that results from a successful solicitation. The parties to the Contract will be the Customer and Contractor.

(b) "Customer" means the State agency or other entity that will order products directly from the Contractor under the Contract.

(c) "Product" means any deliverable under the Contract, which may include commodities, services, technology or software.

(d) "Purchase order" means the form or format a Customer uses to make a purchase under the Contract (e.g., a formal written purchase order, electronic purchase order, procurement card, or other authorized means).

2. Purchase Orders. A Contractor shall not deliver or furnish products until a Customer transmits a purchase order. All purchase orders shall bear the Contract or solicitation number, shall be placed by the Customer directly with the Contractor, and shall be deemed to incorporate by reference the Contract and solicitation terms and conditions. Any discrepancy between the Contract terms and the terms stated on the Contractor's order form, confirmation, or acknowledgement shall be resolved in favor of terms most favorable to the Customer. A purchase order for services within the ambit of section 287.058(1) of the Florida Statutes shall be deemed to incorporate by reference the requirements of subparagraphs (a) through (f) thereof. Customers shall designate a contract manager and a contract administrator as required by subsections 287.057(15) and (16) of the Florida Statutes.

3. Product Version. Purchase orders shall be deemed to reference a manufacturer's most recently release model or version of the product at the time of the order, unless the Customer specifically requests in writing an earlier model or version and the contractor is willing to provide such model or version.

4. Price Changes Applicable only to Term Contracts. If this is a term contract for commodities or services, the following provisions apply.

(a) Quantity Discounts. Contractors are urged to offer additional discounts for one time delivery of large single orders. Customers should seek to negotiate additional price

concessions on quantity purchases of any products offered under the Contract. State Customers shall document their files accordingly.

(b) Best Pricing Offer. During the Contract term, if the Customer becomes aware of better pricing offered by the Contractor for substantially the same or a smaller quantity of a product outside the Contract, but upon the same or similar terms of the Contract, then at the discretion of the Customer the price under the Contract shall be immediately reduced to the lower price.

(c) Sales Promotions. In addition to decreasing prices for the balance of the Contract term due to a change in market conditions, a Contractor may conduct sales promotions involving price reductions for a specified lesser period. A Contractor shall submit to the Contract Specialist documentation identifying the proposed (1) starting and ending dates of the promotion, (2) products involved, and (3) promotional prices compared to then-authorized prices. Promotional prices shall be available to all Customers. Upon approval, the Contractor shall provide conspicuous notice of the promotion.

(d) Trade-In. Customers may trade-in equipment when making purchases from the Contract. A trade-in shall be negotiated between the Customer and the Contractor. Customers are obligated to actively seek current fair market value when trading equipment, and to keep accurate records of the process. For State agencies, it may be necessary to provide documentation to the Department of Financial Services and to the agency property custodian pursuant to Chapter 273, F.S.

(e) Equitable Adjustment. The Customer may, in its sole discretion, make an equitable adjustment in the Contract terms or pricing if pricing or availability of supply is affected by extreme and unforeseen volatility in the marketplace, that is, by circumstances that satisfy all the following criteria: (1) the volatility is due to causes wholly beyond the Contractor's control, (2) the volatility affects the marketplace or industry, not just the particular Contract source of supply, (3) the effect on pricing or availability of supply is substantial, and (4) the volatility so affects the Contractor that continued performance of the Contract would result in a substantial loss.

5. Additional Quantities. For a period not exceeding ninety (90) days from the date of solicitation award, the Customer reserves the right to acquire additional quantities up to the amount shown on the solicitation but not to exceed the threshold for Category Two at the prices submitted in the response to the solicitation.

6. Packaging. Tangible product shall be securely and properly packed for shipment, storage, and stocking in appropriate, clearly labeled, shipping containers and according to accepted commercial practice, without extra charge for packing materials, cases, or other types of containers. All containers and packaging shall become and remain Customer's property.

7. Manufacturer's Name and Approved Equivalents. Unless otherwise specified, any manufacturers' names, trade names, brand names, information or catalog numbers listed in a specification are descriptive, not restrictive. With the Customer's prior approval, the Contractor may provide any product that meets or exceeds the applicable specifications. The Contractor shall demonstrate comparability, including appropriate catalog materials, literature, specifications, test data, etc. The Customer shall determine in its sole discretion whether a product is acceptable as an equivalent.

8. Inspection at Contractor's Site. The Customer reserves the right to inspect, at any reasonable time with prior notice, the equipment or product or plant or other facilities of a Contractor to assess conformity with Contract requirements and to determine whether they are adequate and suitable for proper and effective Contract performance.

9. Safety Standards. All manufactured items and fabricated assemblies subject to operation under pressure, operation by connection to an electric source, or operation involving connection to a manufactured, natural, or LP gas source shall be constructed and approved in a manner acceptable to the appropriate State inspector. Acceptability customarily requires, at a minimum, identification marking of the appropriate safety standard organization, where such approvals of listings have been established for the type of device offered and furnished, for example: the American Society of Mechanical Engineers for pressure vessels; the Underwriters Laboratories and/or National Electrical Manufacturers' Association for electrically operated assemblies; and the American Gas Association for gas-operated assemblies. In addition, all items furnished shall meet all applicable requirements of the Occupational Safety and Health Act and state and federal requirements relating to clean air and water pollution.

10. Americans with Disabilities Act. Contractors should identify any products that may be used or adapted for use by visually, hearing, or other physically impaired individuals.

11. Literature. Upon request, the Contractor shall furnish literature reasonably related to the product offered, for example, user manuals, price schedules, catalogs, descriptive brochures, etc.

12. Transportation and Delivery. Prices shall include all charges for packing, handling, freight, distribution, and inside delivery. Transportation of goods shall be FOB Destination to any point within thirty (30) days after the Customer places an Order. A Contractor, within five (5) days after receiving a purchase order, shall notify the Customer of any potential delivery delays. Evidence of inability or intentional delays shall be cause for Contract cancellation and Contractor suspension.

13. Installation. Where installation is required, Contractor shall be responsible for placing and installing the product in the required locations at no additional charge, unless otherwise designated on the purchase order. Contractor's authorized product and price list shall clearly and separately identify any additional installation charges. All materials used in the installation shall be of good quality and shall be free of defects that would diminish the appearance of the product or render it structurally or operationally unsound.

Installation includes the furnishing of any equipment, rigging, and materials required to install or replace the product in the proper location. Contractor shall protect the site from damage and shall repair damages or injury caused during installation by Contractor or its employees or agents. If any alteration, dismantling, excavation, etc., is required to achieve installation, the Contractor shall promptly restore the structure or site to its original condition. Contractor shall perform installation work so as to cause the least inconvenience and interference with Customers and with proper consideration of others on site. Upon completion of the installation, the location and surrounding area of work shall be left clean and in a neat and unobstructed condition, with everything in satisfactory repair and order.

14. Risk of Loss. Matters of inspection and acceptance are addressed in s. 215.422, F.S. Until acceptance, risk of loss or damage shall remain with the Contractor. The Contractor shall be responsible for filing, processing, and collecting all damage claims. To assist the Contractor with damage claims, the Customer shall: record any evidence of visible damage on all copies of the delivering carrier's Bill of Lading; report damages to the carrier and the Contractor; and provide the Contractor with a copy of the carrier's Bill of Lading and damage inspection report. When a Customer rejects a product, Contractor shall remove it from the premises within ten days after notification or rejection. Upon rejection notification, the risk of loss of rejected or non-conforming product shall remain with the Contractor. Rejected product not removed by the Contractor within ten days shall be deemed abandoned by the Contractor, and the Customer shall have the right to dispose of it as its own property. Contractor shall reimburse the Customer for costs and expenses incurred in storing or effecting removal or disposition of rejected product.

15. Transaction Fee. The State of Florida has instituted MyFloridaMarketPlace, a statewide eProcurement System ("System"). Pursuant to section 287.057(23), Florida Statutes (2002), all payments shall be assessed a Transaction Fee of one percent (1.0%), which the Contractor shall pay to the State, unless exempt pursuant to 60A-1.032, F.A.C.

For payments within the State accounting system (FLAIR or its successor), the Transaction Fee shall, when possible, be automatically deducted from payments to the Contractor. If automatic deduction is not possible, the Contractor shall pay the Transaction Fee pursuant to Rule 60A-1.031(2), F.A.C. By submission of these reports and corresponding payments, Contractor certifies their correctness. All such reports and payments shall be subject to audit by the State or its designee.

Contractor shall receive a credit for any Transaction Fee paid by the Contractor for the purchase of any item(s) if such item(s) are returned to the Contractor through no fault, act, or omission of the Contractor. Notwithstanding the foregoing, a Transaction Fee is non-refundable when an item is rejected or returned, or declined, due to the Contractor's failure to perform or comply with specifications or requirements of the agreement.

Failure to comply with these requirements shall constitute grounds for declaring the Contractor in default and recovering reprocurement costs from the Contractor in addition to all outstanding fees. **CONTRACTORS DELINQUENT IN PAYING TRANSACTION FEES SHALL BE EXCLUDED FROM CONDUCTING FUTURE BUSINESS WITH THE STATE.**

16. Invoicing and Payment. Invoices shall contain the Contract number, purchase order number, and the appropriate vendor identification number. The State may require any other information from the Contractor that the State deems necessary to verify any purchase order placed under the Contract.

At the State's option, Contractors may be required to invoice electronically pursuant to guidelines of the Department of Management Services. Current guidelines require that Contractor supply electronic invoices in lieu of paper-based invoices for those transactions processed through the system. Electronic invoices shall be submitted to the Customer through the Ariba Supplier Network (ASN) in one of the following mechanisms – EDI 810, cXML, or web-based invoice entry within the ASN.

Payment shall be made in accordance with sections 215.422 and 287.0585 of the Florida Statutes, which govern time limits for payment of invoices. Invoices that must be returned to a Contractor due to preparation errors will result in a delay in payment. Contractors may call (850) 413-7269 Monday through Friday to inquire about the status of payments by State Agencies. The Customer is responsible for all payments under the Contract. A Customer's failure to pay, or delay in payment, shall not constitute a breach of the Contract and shall not relieve the Contractor of its obligations to the Department or to other Customers.

17. Taxes. The State does not pay Federal excise or sales taxes on direct purchases of tangible personal property. The State will not pay for any personal property taxes levied on the Contractor or for any taxes levied on employees' wages. Any exceptions to this paragraph shall be explicitly noted by the Customer on a purchase order or other special contract condition.

18. Governmental Restrictions. If the Contractor believes that any governmental restrictions have been imposed that require alteration of the material, quality, workmanship or performance of the products offered under the Contract, the Contractor shall immediately notify the Customer in writing, indicating the specific restriction. The Customer reserves the right and the complete discretion to accept any such alteration or to cancel the Contract at no further expense to the Customer.

19. Lobbying and Integrity. Customers shall ensure compliance with Section 11.062, FS and Section 216.347, FS.The Contractor shall not, in connection with this or any other agreement with the State, directly or indirectly (1) offer, confer, or agree to confer any pecuniary benefit on anyone as consideration for any State officer or employee's decision, opinion, recommendation, vote, other exercise of discretion, or violation of a known legal duty, or (2) offer, give, or agree to give to anyone any gratuity for the benefit of, or at the direction or request of, any State officer or employee. For purposes of clause (2), "gratuity" means any payment of more than nominal monetary value in the form of cash, travel, entertainment, gifts, meals, lodging, loans, subscriptions, advances, deposits of money, services, employment, or contracts of any kind. Upon request of the Customer's Inspector General, or other authorized State official, the Contractor shall provide any type of information the Inspector General deems relevant to the Contractor's integrity or responsibility. Such information may include, but shall not be limited to, the Contractor's business or financial records, documents, or files of any type or form that

refer to or relate to the Contract. The Contractor shall retain such records for the longer of (1) three years after the expiration of the Contract or (2) the period required by the General Records Schedules maintained by the Florida Department of State (available at: http://dlis.dos.state.fl.us/barm/genschedules/gensched.htm). The Contractor agrees to reimburse the State for the reasonable costs of investigation incurred by the Inspector General or other authorized State official for investigations of the Contractor's compliance with the terms of this or any other agreement between the Contractor and the State which results in the suspension or debarment of the Contractor. Such costs shall include, but shall not be limited to: salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. The Contractor shall not be responsible for any costs of investigations that do not result in the Contractor's suspension or debarment.

20. Indemnification. The Contractor shall be fully liable for the actions of its agents, employees, partners, or subcontractors and shall fully indemnify, defend, and hold harmless the State and Customers, and their officers, agents, and employees, from suits, actions, damages, and costs of every name and description, including attorneys' fees, arising from or relating to personal injury and damage to real or personal tangible property alleged to be caused in whole or in part by Contractor, its agents, employees, partners, or subcontractors, provided, however, that the Contractor shall not indemnify for that portion of any loss or damages proximately caused by the negligent act or omission of the State or a Customer.

Further, the Contractor shall fully indemnify, defend, and hold harmless the State and Customers from any suits, actions, damages, and costs of every name and description, including attorneys' fees, arising from or relating to violation or infringement of a trademark, copyright, patent, trade secret or intellectual property right, provided, however, that the foregoing obligation shall not apply to a Customer's misuse or modification of Contractor's products or a Customer's operation or use of Contractor's products in a manner not contemplated by the Contract or the purchase order. If any product is the subject of an infringement suit, or in the Contractor's opinion is likely to become the subject of such a suit, the Contractor may at its sole expense procure for the Customer the right to continue using the product or to modify it to become non-infringing. If the Contractor is not reasonably able to modify or otherwise secure the Customer the right to continue using the product, the Contractor shall remove the product and refund the Customer the amounts paid in excess of a reasonable rental for past use. The customer shall not be liable for any royalties.

The Contractor's obligations under the preceding two paragraphs with respect to any legal action are contingent upon the State or Customer giving the Contractor (1) written notice of any action or threatened action, (2) the opportunity to take over and settle or defend any such action at Contractor's sole expense, and (3) assistance in defending the action at Contractor's sole expense. The Contractor shall not be liable for any cost, expense, or compromise incurred or made by the State or Customer in any legal action without the Contractor's prior written consent, which shall not be unreasonably withheld.

21. Limitation of Liability. For all claims against the Contractor under any individual purchase order, and regardless of the basis on which the claim is made, the Contractor's liability under a purchase order for direct damages shall be limited to the greater of $100,000, the dollar amount of the purchase order, or two times the charges rendered by the Contractor under the purchase order. This limitation shall not apply to claims arising under the Indemnity paragraph contain in this agreement.

Unless otherwise specifically enumerated in the Contract or in the purchase order, no party shall be liable to another for special, indirect, punitive, or consequential damages, including lost data or records (unless the purchase order requires the Contractor to back-up data or records), even if the party has been advised that such damages are possible. No party shall be liable for lost profits, lost revenue, or lost institutional operating savings. The State and Customer may, in addition to other remedies available to them at law or equity and upon notice to the Contractor, retain such monies from amounts due Contractor as may be necessary to satisfy any claim for damages, penalties, costs and the like asserted by or against them. The State may set off any liability or other obligation of the Contractor or its affiliates to the State against any payments due the Contractor under any contract with the State.

22. Suspension of Work. The Customer may in its sole discretion suspend any or all activities under the Contract, at any time, when in the best interests of the State to do so. The Customer shall provide the Contractor written notice outlining the particulars of suspension. Examples of the reason for suspension include, but are not limited to, budgetary constraints, declaration of emergency, or other such circumstances. After receiving a suspension notice, the Contractor shall comply with the notice and shall not accept any purchase orders. Within ninety days, or any longer period agreed to by the Contractor, the Customer shall either (1) issue a notice authorizing resumption of work, at which time activity shall resume, or (2) terminate the Contract. Suspension of work shall not entitle the Contractor to any additional compensation.

23. Termination for Convenience. The Customer, by written notice to the Contractor, may terminate the Contract in whole or in part when the Customer determines in its sole discretion that it is in the State's interest to do so. The Contractor shall not furnish any product after it receives the notice of termination, except as necessary to complete the continued portion of the Contract, if any. The Contractor shall not be entitled to recover any cancellation charges or lost profits.

24. Termination for Cause. The Customer may terminate the Contract if the Contractor fails to (1) deliver the product within the time specified in the Contract or any extension, (2) maintain adequate progress, thus endangering performance of the Contract, (3) honor any term of the Contract, or (4) abide by any statutory, regulatory, or licensing requirement. Rule 60A-1.006(3), F.A.C., governs the procedure and consequences of default. The Contractor shall continue work on any work not terminated. 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 events completely beyond the control, and without the fault or negligence, of the Contractor. If the failure to perform is

caused by the default of a subcontractor at any tier, and if the cause of the default is completely beyond the control of both the Contractor and the 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 products were obtainable from other sources in sufficient time for the Contractor to meet the required delivery schedule. If, after termination, it is determined that the Contractor was not in default, or that the default was excusable, the rights and obligations of the parties shall be the same as if the termination had been issued for the convenience of the Customer. The rights and remedies of the Customer in this clause are in addition to any other rights and remedies provided by law or under the Contract.

25. Force Majeure, Notice of Delay, and No Damages for Delay. The Contractor shall not be responsible for delay resulting from its failure to perform if neither the fault nor the negligence of the Contractor or its employees or agents contributed to the delay and the delay is due directly to acts of God, wars, acts of public enemies, strikes, fires, floods, or other similar cause wholly beyond the Contractor's control, or for any of the foregoing that affect subcontractors or suppliers if no alternate source of supply is available to the Contractor. In case of any delay the Contractor believes is excusable, the Contractor shall notify the Customer in writing of the delay or potential delay and describe the cause of the delay either (1) within ten (10) days after the cause that creates or will create the delay first arose, if the Contractor could reasonably foresee that a delay could occur as a result, or (2) if delay is not reasonably foreseeable, within five (5) days after the date the Contractor first had reason to believe that a delay could result. **THE FOREGOING SHALL CONSTITUTE THE CONTRACTOR'S SOLE REMEDY OR EXCUSE WITH RESPECT TO DELAY.** Providing notice in strict accordance with this paragraph is a condition precedent to such remedy. No claim for damages, other than for an extension of time, shall be asserted against the Customer. The Contractor shall not be entitled to an increase in the Contract price or payment of any kind from the Customer for direct, indirect, consequential, impact or other costs, expenses or damages, including but not limited to costs of acceleration or inefficiency, arising because of delay, disruption, interference, or hindrance from any cause whatsoever. If performance is suspended or delayed, in whole or in part, due to any of the causes described in this paragraph, after the causes have ceased to exist the Contractor shall perform at no increased cost, unless the Customer determines, in its sole discretion, that the delay will significantly impair the value of the Contract to the State or to Customers, in which case the Customer may (1) accept allocated performance or deliveries from the Contractor, provided that the Contractor grants preferential treatment to Customers with respect to products subjected to allocation, or (2) purchase from other sources (without recourse to and by the Contractor for the related costs and expenses) to replace all or part of the products that are the subject of the delay, which purchases may be deducted from the Contract quantity, or (3) terminate the Contract in whole or in part.

26. Scope Changes. The Customer may unilaterally require, by written order, changes altering, adding to, or deducting from the Contract specifications, provided that such changes are within the general scope of the Contract. The Customer may make an equitable adjustment in the Contract price or delivery date if the change affects the cost

or time of performance. Such equitable adjustments require the written consent of the Contractor, which shall not be unreasonably withheld. If unusual quantity requirements arise, the Customer may solicit separate bids to satisfy them.

27. Renewal. Upon mutual agreement, the Customer and the Contractor may renew the Contract, in whole or in part, for a period that may not exceed 3 years or the term of the contract, whichever period is longer. Any renewal shall specify the renewal price, as set forth in the solicitation response. The renewal must be in writing and signed by both parties, and is contingent upon satisfactory performance evaluations and subject to availability of funds.

28. Advertising. Subject to Chapter 119, Florida Statutes, the Contractor shall not publicly disseminate any information concerning the Contract without prior written approval from the Customer, including, but not limited to mentioning the Contract in a press release or other promotional material, identifying the Customer or the State as a reference, or otherwise linking the Contractor's name and either a description of the Contract or the name of the State or the Customer in any material published, either in print or electronically, to any entity that is not a party to Contract, except potential or actual authorized distributors, dealers, resellers, or service representative.

29. Assignment. The Contractor shall not sell, assign or transfer any of its rights, duties or obligations under the Contract, or under any purchase order issued pursuant to the Contract, without the prior written consent of the Customer; provided, the Contractor assigns to the State any and all claims it has with respect to the Contract under the antitrust laws of the United States and the State. In the event of any assignment, the Contractor remains secondarily liable for performance of the contract, unless the Customer expressly waives such secondary liability. The Customer may assign the Contract with prior written notice to Contractor of its intent to do so.

30. Dispute Resolution. Any dispute concerning performance of the Contract shall be decided by the Customer's designated contract manager, who shall reduce the decision to writing and serve a copy on the Contractor. The decision shall be final and conclusive unless within ten (10) days from the date of receipt, the Contractor files with the Customer a petition for administrative hearing. The Customer's decision on the petition shall be final, subject to the Contractor's right to review pursuant to Chapter 120 of the Florida Statutes. Exhaustion of administrative remedies is an absolute condition precedent to the Contractor's ability to pursue any other form of dispute resolution; provided, however, that the parties may employ the alternative dispute resolution procedures outlined in Chapter 120.

Without limiting the foregoing, the exclusive venue of any legal or equitable action that arises out of or relates to the Contract shall be the appropriate state court in Leon County, Florida; in any such action, Florida law shall apply and the parties waive any right to jury trial.

31. Employees, Subcontractors, and Agents. All Contractor employees, subcontractors, or agents performing work under the Contract shall be properly trained technicians who meet or exceed any specified training qualifications. Upon request, Contractor shall furnish a copy of technical certification or other proof of qualification. All employees, subcontractors, or agents performing work under the Contract must comply with all security and administrative requirements of the Customer. The State may conduct, and the Contractor shall cooperate in, a security background check or otherwise assess any employee, subcontractor, or agent furnished by the Contractor. The State may refuse access to, or require replacement of, any personnel for cause, including, but not limited to, technical or training qualifications, quality of work, change in security status, or non-compliance with a Customer's security or other requirements. Such approval shall not relieve the Contractor of its obligation to perform all work in compliance with the Contract. The State may reject and bar from any facility for cause any of the Contractor's employees, subcontractors, or agents.

32. Security and Confidentiality. The Contractor shall comply fully with all security procedures of the State and Customer in performance of the Contract. The Contractor shall not divulge to third parties any confidential information obtained by the Contractor or its agents, distributors, resellers, subcontractors, officers or employees in the course of performing Contract work, including, but not limited to, security procedures, business operations information, or commercial proprietary information in the possession of the State or Customer. The Contractor shall not be required to keep confidential information or material that is publicly available through no fault of the Contractor, material that the Contractor developed independently without relying on the State's or Customer's confidential information, or material that is otherwise obtainable under State law as a public record. To insure confidentiality, the Contractor shall take appropriate steps as to its personnel, agents, and subcontractors. The warranties of this paragraph shall survive the Contract.

33.Contractor Employees, Subcontractors, and Other Agents. The Customer and the State shall take all actions necessary to ensure that Contractor's employees, subcontractors and other agents are not employees of the State of Florida. Such actions include, but are not limited to, ensuring that Contractor's employees, subcontractors, and other agents receive benefits and necessary insurance (health, workers' compensations, and unemployment) from an employer other than the State of Florida.

34. Insurance Requirements. During the Contract term, the Contractor at its sole expense shall provide commercial insurance of such a type and with such terms and limits as may be reasonably associated with the Contract. Providing and maintaining adequate insurance coverage is a material obligation of the Contractor. Upon request, the Contractor shall provide certificate of insurance. The limits of coverage under each policy maintained by the Contractor shall not be interpreted as limiting the Contractor's liability and obligations under the Contract. All insurance policies shall be through insurers authorized or eligible to write policies in Florida.

35. Warranty of Authority. Each person signing the Contract warrants that he or she is duly authorized to do so and to bind the respective party to the Contract.

36. Warranty of Ability to Perform. The Contractor warrants that, to the best of its knowledge, there is no pending or threatened action, proceeding, or investigation, or any other legal or financial condition, that would in any way prohibit, restrain, or diminish the Contractor's ability to satisfy its Contract obligations. The Contractor warrants that neither it nor any affiliate is currently on the convicted vendor list maintained pursuant to section 287.133 of the Florida Statutes, or on any similar list maintained by any other state or the federal government. The Contractor shall immediately notify the Customer in writing if its ability to perform is compromised in any manner during the term of the Contract.

37. Notices. All notices required under the Contract shall be delivered by certified mail, return receipt requested, by reputable air courier service, or by personal delivery to the agency designee identified in the original solicitation, or as otherwise identified by the Customer. Notices to the Contractor shall be delivered to the person who signs the Contract. Either designated recipient may notify the other, in writing, if someone else is designated to receive notice.

38. Leases and Installment Purchases. Prior approval of the Chief Financial Officer (as defined in Section 17.001, F.S.) is required for State agencies to enter into or to extend any lease or installment-purchase agreement in excess of the Category Two amount established by section 287.017 of the Florida Statutes.

39. Prison Rehabilitative Industries and Diversified Enterprises, Inc. (PRIDE). Section 946.515(2), F.S. requires the following statement to be included in the solicitation: "It is expressly understood and agreed that any articles which are the subject of, or required to carry out, the Contract shall be purchased from the corporation identified under Chapter 946 of the Florida Statutes (PRIDE) in the same manner and under the same procedures set forth in section 946.515(2) and (4) of the Florida Statutes; and for purposes of the Contract the person, firm, or other business entity carrying out the provisions of the Contract shall be deemed to be substituted for the agency insofar as dealings with such corporation are concerned." Additional information about PRIDE and the products it offers is available at http://www.pridefl.com.

40. Products Available from the Blind or Other Handicapped. Section 413.036(3), F.S. requires the following statement to be included in the solicitation: "It is expressly understood and agreed that any articles that are the subject of, or required to carry out, this contract shall be purchased from a nonprofit agency for the Blind or for the Severely Handicapped that is qualified pursuant to Chapter 413, Florida Statutes, in the same manner and under the same procedures set forth in section 413.036(1) and (2), Florida Statutes; and for purposes of this contract the person, firm, or other business entity carrying out the provisions of this contract shall be deemed to be substituted for the State agency insofar as dealings with such qualified nonprofit agency are concerned." Additional information about the designated nonprofit agency and the products it offers is available at http://www.respectofflorida.org.

41. Modification of Terms. The Contract contains all the terms and conditions agreed upon by the parties, which terms and conditions shall govern all transactions between the Customer and the Contractor. The Contract may only be modified or amended upon mutual written agreement of the Customer and the Contractor. No oral agreements or representations shall be valid or binding upon the Customer or the Contractor. No alteration or modification of the Contract terms, including substitution of product, shall be valid or binding against the Customer. The Contractor may not unilaterally modify the terms of the Contract by affixing additional terms to product upon delivery (e.g., attachment or inclusion of standard preprinted forms, product literature, "shrink wrap" terms accompanying or affixed to a product, whether written or electronic) or by incorporating such terms onto the Contractor's order or fiscal forms or other documents forwarded by the Contractor for payment. The Customer's acceptance of product or processing of documentation on forms furnished by the Contractor for approval or payment shall not constitute acceptance of the proposed modification to terms and conditions.

42. Cooperative Purchasing. Pursuant to their own governing laws, and subject to the agreement of the Contractor, other entities may be permitted to make purchases at the terms and conditions contained herein. Non-Customer purchases are independent of the agreement between Customer and Contractor, and Customer shall not be a party to any transaction between the Contractor and any other purchaser.
State agencies wishing to make purchases from this agreement are required to follow the provisions of s. 287.042(16)(a), F.S. This statute requires the Department of Management Services to determine that the requestor's use of the contract is cost-effective and in the best interest of the State.

43. Waiver. The delay or failure by the Customer to exercise or enforce any of its rights under this Contract shall not constitute or be deemed a waiver of the Customer's right thereafter to enforce those rights, nor shall any single or partial exercise of any such right preclude any other or further exercise thereof or the exercise of any other right.

44. Annual Appropriations. The State's performance and obligation to pay under this contract are contingent upon an annual appropriation by the Legislature.

45. Execution in Counterparts. The Contract may be executed in counterparts, each of which shall be an original and all of which shall constitute but one and the same instrument.

46. Severability. If a court deems any provision of the Contract void or unenforceable, that provision shall be enforced only to the extent that it is not in violation of law or is not otherwise unenforceable and all other provisions shall remain in full force and effect.

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APPENDICES

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10 GENERAL OVERVIEW

10.1 General Background

The Agency for Health Care Administration (Agency) is the single State agency responsible for administering the Medicaid program in Florida. The Florida Medicaid Program provides medical services to eligible Medicaid recipients under Title XIX (Medicaid) and to children between the ages of 0-5 under Title XXI (State Children's Health Insurance Program) of the Social Security Act through enrolled providers.

10.2 Purpose

This Request for Proposal (RFP) is issued to solicit proposals to develop a new Florida Medicaid Management Information System (FMMIS), a new Decision Support System (DSS) and to provide fiscal agent operations. It is the intent of the State that this RFP permit fair, impartial and free competition among all Vendors.

The Prime Contractor will be responsible for all Contractor requirements defined in this RFP throughout the term of the contract. However, the Agency encourages the Prime Contractor to form partnerships with entities that are the business leaders in their industry. Vendors responding to this RFP will be expected to have extensive, current experience as a fiscal agent or intermediary for Medicaid or a similar large health care claims processing entity.

It is critical that interested Vendors carefully read, study, analyze, and understand all sections and provisions of the RFP and reference material contained in the Medicaid Procurement Library. The selected Contractor will be required to design, develop, test, implement, and operate a replacement system for FMMIS and the Florida Medicaid DSS, and provide fiscal agent services.

The objectives for the MMIS and DSS should include:

1. A replacement system that is driven by a relational database with online Web capabilities for all authorized users, including providers and recipients.
2. Rules-based structure to allow for easy modification to edits by authorized users to eliminate the delays and programming issues related to hard coding. This will ensure timely implementation of changes thus reducing the need for programmers and excessive numbers of customer service requests.
3. The ability to grant access permissions down to the data element level to ensure compliance with HIPAA security requirements, preserve recipient Protected Health Information (PHI), and provide audit trails for all changes.
4. Geographical information systems (GIS) capability to help Medicaid administrators, managers, and client service staff understand such things as quantity, density, and proximity to better serve their Medicaid population.
5. Online real-time query capability that allows authorized users to filter data through user-defined parameters.
6. Real-time or near real-time adjudication of claims, including the application of edits, audits, and service authorizations for all kinds of services. Service authorizations include MediPass referrals and services now authorized through ancillary systems, such as the Service Authorization System.

7. Online entry of provider enrollment applications; tracking and automated workflow management of the process; and online verification of provider enrollment status.
8. Graphical user interfaces (GUIs) to include pull-down menus, buttons, scroll bars, icons, wizards, and templates. These features should be used in a manner to allow simplified query construction and report design to match the skill level of a majority of the user community. In much the same way that Microsoft Windows improved user understanding of operating systems and applications on the user's desktop, the new FMMIS/DSS should improve the user's understanding of and access to the system.
9. Real-time, online ability to enter claims by direct data entry (DDE), obtain recipient eligibility verification, conduct claim status inquiry, view remittance and status reports, and submit and view the status of service authorization requests via Web screens for authorized providers and other users.
10. The ability to send and receive all HIPAA transaction sets, intake imaged and scanned documents, and automatically link both the HIPAA transaction and the imaged document together in history.
11. The utilization of Commercial-Off-The-Shelf (COTS) products whenever possible. This would ensure that the various system and software components remain current, readily available, and easily upgradeable. Selecting the right product Vendor is also important to ensure that modifications and customization needed by the State are easily accomplished with little to no cost.
12. A portal to provide recipients with online and real-time ability to view their data, to make authorized changes, to request PHI, to see claims filed for services rendered by providers, to quickly and easily select managed care plans and to update or select primary care physicians.
13. The ability to accept, process and report encounter data.
14. The ability to accept, verify and process claims using the National Provider Identifier in accordance with all applicable federal regulations.
15. Increased automation and system integration and decreased reliance on manual processes.
16. Capabilities that allow for continual modernization to support implementation of innovative technologies.

10.3 Issuing Officer

This RFP is issued by the Agency for Health Care Administration. The individual listed below is the sole point of contact from the date of release of this RFP until the contract award.

Angela Smith
Medicaid Procurement Team Lead
Bureau of Medicaid Contract Management
2308 Killearn Center Boulevard, Suite 200
Tallahassee, Florida 32309
Fax: (850) 413-8102

Email: smitha@ahca.myflorida.com

10.4 Contracting Officer

The Contracting Officer is responsible for overseeing the entire fiscal agent operation and for monitoring and assessing fiscal agent contractor performance. The Contracting Officer for this contract is:

Alan Levine
Secretary, Agency for Health Care Administration
2727 Mahan Drive Mail Stop 1
Tallahassee, Florida 32308
Fax: (850) 488-0043

10.5 RFP Organization

Section 10 General Overview
This section contains a general overview of the procurement.

Section 20 RFP Process
This section explains the procurement process for this solicitation.

Section 30 Contract Terms and Conditions
This section contains the terms and conditions that will apply to the resulting contract.

Section 40 Technical and Business Process Requirements
This section describes the technical requirements of the Contractor procured with this RFP.

Section 50 Scope of Work
This section outlines the scope of the work to be performed during the contract period.

Section 60 Proposal Instructions
This section contains instructions to the Vendors regarding how the proposal should be presented to the Agency. This section contains the Exhibits of the Cost Proposal Sheets, which must be used by the Vendors to submit their Cost Proposals.

Section 70 Technical Proposal Evaluation
This section describes the criteria that will be used to evaluate the Technical Proposals.

Section 80 Cost Proposal Evaluation
This section describes the criteria that will be used to evaluate the Cost Proposals.

Section 90 Ranking of Proposals
This section describes the process of ranking the proposals and awarding the resulting contract.

Attachments
The attachments are required forms for the resulting contract.

Appendices
The appendices contain additional information that the Vendors will need to prepare their responses. Other pertinent information will be placed in the Medicaid Procurement Library, which is available upon request. A list of the items in the Medicaid Procurement Library is found in Appendix D.

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20 RFP PROCESS

20.1 RFP Timetable

The projected timetable is shown below (all times are Eastern time). Unless otherwise indicated, the times will be as of the close of business (5:00 p. m.) on the date specified. The Agency reserves the right to amend the RFP timetable in the State's best interests. If the Agency finds it necessary to change any of these activities/dates/times, interested organizations will be notified by addendum to the RFP.

ACTIVITY	DATE and TIME	LOCATION
RFP Issued by Agency	3/3/2005	DMS Web Site Web address listed below this chart
Vendor's Conference	3/23/2005 1:30 p. m.	Agency for Health Care Administration 2727 Mahan Drive, Building 3 Conference Center Tallahassee, FL 32308-5403
Deadline for Notice of Intent to Submit a Proposal	3/23/2005 1:30 p. m.	Agency for Health Care Administration 2727 Mahan Drive, MS #56 Building 2, Room 203 Tallahassee, FL 32308-5403
Deadline for Receipt of Written Inquiries	4/15/2005	Agency for Health Care Administration 2727 Mahan Drive, MS #56 Building 2, Room 203 Tallahassee, FL 32308-5403
Anticipated Date for Agency Responses to Written Inquiries	5/2/2005	DMS Web site Web address listed below this chart
Deadline for Receipt of Proposals	6/2/2005 5:00 p. m.	Agency for Health Care Administration 2727 Mahan Dr., MS #56 Building 2, Room 203 Tallahassee, FL 32308-5403
Public Opening of Technical Proposals	6/3/2005 1:30 p. m.	Agency for Health Care Administration 2727 Mahan Drive, Building 3 Conference Center Tallahassee, FL 32308-5403
Anticipated Date for Completion of Evaluation of Technical Proposals	8/15/2005	N/A
Public Opening of Cost Proposals	8/19/2005 1:30 p. m.	Agency for Health Care Administration 2727 Mahan Drive, Building 3 Conference Center Tallahassee, FL 32308-5403
Posting of Notice of Intent to Award	9/2/2005	DMS Web site Web address listed below this chart

DMS Web site: http://fcn.state.fl.us/owa_vbs/owa/vbs_www.search.criteria_form

20.2 Solicitation Rules

This solicitation is being conducted under the rules of procurement in the Chapters 120 and 287, Florida Statutes and Rules 28-110 and 60A-1 Florida Administrative Code (FAC) and in the Code of Federal Regulations (CFR). The Department of Management Services purchasing forms PUR 1000 and 1001 are included in this RFP and the resulting contract. In the event of a conflict in language between the PUR documents referenced above and the provisions set forth in the RFP, the provisions in the RFP will supercede the PUR form provisions. The following Items on the PUR 1000 form do not apply to this solicitation: 1. Definitions (b) "Customer"; 4. Price Changes Applicable only to Term Contracts. (c) Sales Promotions; 15. Transaction Fee; 21. Limitation of Liability; 30. Dispute Resolution. The following Item on the PUR 1001 form does not apply to this solicitation: 14. Clarifications/Revisions.

The State has established certain requirements with respect to responses submitted to competitive solicitations. The use of "shall", "must", or "will" (except to indicate futurity) in this solicitation, indicates a requirement or condition from which a material deviation may not be waived by the State. A deviation is material if, in the State's sole discretion, the deficient response is not in substantial accord with the solicitation requirements, provides an advantage to one respondent over another, or has a potentially significant effect on the quality of the response or on the cost to the State. Material deviations cannot be waived. The words "should" or "may" in this solicitation indicate desirable attributes or conditions, but are permissive in nature. Deviation from, or omission of, such desirable feature will not in itself cause rejection of a response.

20.3 Restrictions on Communications

The sole point of contact for information concerning this RFP is the Issuing Officer identified in Section 10.3. All other communications between a Vendor and staff of the Agency concerning this RFP are prohibited. In no instance is a Vendor to discuss cost information contained in the Cost Proposal with the Issuing Officer or any other Agency staff prior to the opening of the Cost Proposals.

20.4 Protest of the RFP

Any actual or prospective Vendor, that desires to file a formal protest to this RFP, as outlined in Item 19 of the PUR 1001 form, must accompany that protest with a bond payable to the Agency in an amount equal to one percent of the Agency's estimate of the total volume of the contract, as presented in the approved Advance Planning Document (APD) for this procurement. The bond shall be conditioned upon the payment of all costs, which may be adjudged against the vendor in the administrative hearing in which the action is brought and in any subsequent appellate court proceeding. In lieu of a bond, the Agency may accept a cashier's check or a money order in the amount of the bond.

Failure to file a protest within the time prescribed in section 120.57(3), Florida Statutes, or failure to post the bond or other security required by law within the time allowed for filing a bond shall constitute a waiver of proceedings under Chapter 120, Florida Statutes.

20.5 Notice of Intent to Submit a Proposal

Vendors should submit a Notice of Intent to Submit proposals by the date and time specified in Section 20.1 of this RFP. After that date, materials relative to this procurement will be sent only to those organizations submitting a Notice of Intent to Submit a proposal. However, failure to submit a Notice of Intent to Submit a proposal does not preclude an organization from submitting a proposal.

20.6 Vendors' Conference

The Agency will hold a Vendors' Conference on the date, time, and place shown in Section 20.1 of this RFP. The purpose of the conference is to discuss the contents of the RFP and provide informal answers to questions from potential Vendors. Attendance at this conference is not mandatory. The Agency will accept oral questions during the conference and make a reasonable effort to provide answers at that time; however, oral answers and discussions are not binding. Only written responses to Vendor questions are binding upon the Agency.

Impromptu questions will be permitted and spontaneous answers provided at the State's discretion. Verbal answers at the Vendors' Conference are only intended for general direction and do not represent the Agency's final position. Official answers will be provided in writing. All oral questions must be submitted in writing following the close of the Vendors' Conference, but no later than the date and time specified in the Section 20.1 in order to generate a official answers.

Vendors are encouraged to submit written questions prior to the conference. All communication from Vendors must be made with the Issuing Officer, as listed in Section 10.3.

20.7 Questions about this RFP

Questions or requests for clarification of any part of this RFP must be received in writing by the Issuing Officer (see Section 10.3, Issuing Officer) by the date and time specified in the RFP Timetable in Section 20.1. Inquiries must identify the organization submitting the inquiry and shall be submitted electronically by email to the Issuing Officer or on diskette or CD. Questions must be submitted in the format prescribed in Appendix P of this RFP. Electronic documents should be submitted using Microsoft Word or Excel 2000. The Issuing Officer shall provide a copy of all questions and the Agency's responses to each Vendor that submitted a Notice of Intent to Submit a Proposal by the time specified in Section 20.1 and the questions and answers will be posted as addenda to the RFP on the DMS Web site: http://fcn.state.fl.us/owa_vbs/owa/vbs_www.search.criteria_form. It is the responsibility of each Vendor to obtain the questions and answers and to consider these materials in their response to this RFP.

20.8 RFP Addenda

The Agency reserves the right to amend this RFP at any time prior to the proposal deadline. Amendments will be issued as addenda to the RFP and will be labeled as such. All addenda issued regarding this RFP will be provided to each Vendor that filed a Notice of Intent to Submit a Proposal by the time specified in Section 20.1 and the addenda will be posted on the DMS Web site: http://fcn.state.fl.us/owa_vbs/owa/vbs_www.search.criteria_form. It is the responsibility of

each Vendor to obtain any issued addenda and to consider these materials in their response to this RFP.

20.9 Cost of Proposal Preparation

The costs related to the development and submission of a proposal in response to this RFP are the full responsibility of the Vendor and are not chargeable to the Agency.

20.10 Prohibition of Gratuities

By submission of a proposal, a Vendor certifies that no elected official or employee of the State of Florida has or shall benefit financially or materially from such proposal or subsequent contract in violation of the provisions of Chapter 112, Florida Statutes. Any contract issued as a result of this RFP may be terminated at such time as it is determined that gratuities of any kind were either offered or received by any of the aforementioned persons.

20.11 Independent Preparation of Proposal

A Vendor shall not, directly or indirectly, collude, consult, communicate, or agree with any other Vendor as to any matter relating to the proposal each is submitting. Additionally, a Vendor shall not induce any other entity to submit or not to submit a proposal.

20.12 Proposal Guarantee

One proposal guarantee must be included in the sealed package with the original Technical Proposal.

The original Technical Proposal shall be accompanied by a proposal guarantee payable to the State of Florida in the amount of $500,000.00. The form of the proposal guarantee shall be a bond, cashier's check, treasurer's check, bank draft, or certified check. If the proposal guarantee is a bond, the bond shall be written by a surety company authorized to do business in the State of Florida and signed by a Florida Licensed Agent. If a non-resident Florida Licensed Agent signs the bond, the bond shall be considered to have been made and executed in the State of Florida. All proposal guarantees shall be returned upon execution of a legal contract with the successful Vendor. If the successful Vendor fails to execute a contract within ten (10) consecutive calendar days after a contract has been presented to the Vendor for signature, the proposal guarantee shall be forfeited to the State. The proposal guarantee from the successful Vendor shall be returned only after the Agency has received the performance bond required under Section 30.24 of this RFP.

FAILURE TO INCLUDE THE PROPOSAL GUARANTEE WITH THE SUBMISSION OF THE ORIGINAL TECHNICAL PROPOSAL WILL RESULT IN REJECTION OF A VENDOR'S PROPOSAL.

20.13 Proposal Submission Requirements

A Vendor must submit an original and twelve (12) duplicate copies of its Technical Proposal; and one original and five (5) copies of its Cost Proposal to the Issuing Officer at the address provided in Subsection 10.3 of this RFP.

The Vendor must also submit an electronic copy of the Technical Proposal and the Cost Proposal along with the original paper copies. The electronic copy may be submitted on

diskettes or CD-ROM; however, the Technical Proposal and Cost Proposal must be submitted on separate disks. The software used to produce the electronic copies must be Microsoft 2000 compatible. The electronic copy must be clearly labeled in the same manner as the paper copies.

The proposals, with all required documentation, must be separated into two components: a Technical Proposal and a Cost Proposal. The format and content of each are specified in Section 60 of this RFP. Each component of the proposal must be submitted in a separate, sealed package and clearly labeled as follows:

Original Technical Proposal
Name of Vendor
RFP Number 0514
Time and Date of Proposal Opening
Vendor's Federal Identification Number

and

Original Cost Proposal
Name of Vendor
RFP Number 0514
Time and Date of Proposal Opening
Vendor's Federal Identification Number

FAILURE TO CLEARLY LABEL AND SUBMIT THE ORIGINAL TECHNICAL PROPOSAL AND THE ORIGINAL COST PROPOSAL IN SEPARATELY SEALED PACKAGES WILL RESULT IN REJECTION OF A VENDOR'S PROPOSAL.

The duplicate copies of the Vendor's proposals must be identical to the original, including all required documentation, and must also be submitted in two components: sealed packages containing the electronic copy and the twelve paper duplicates of the Technical Proposals and sealed packages containing the electronic copy and five paper duplicates of the Cost Proposals. Duplicate copies of Technical and Cost Proposal diskettes or CDs are not required. Each package is to be clearly labeled as follows:

Duplicate Technical Proposals
Name of Vendor
RFP Number 0514

and

Duplicate Cost Proposals
Name of Vendor
RFP Number 0514

FAILURE TO CLEARLY LABEL AND SUBMIT DUPLICATE TECHNICAL AND DUPLICATE COST PROPOSALS IN SEPARATE SEALED PACKAGES WILL RESULT IN REJECTION OF A VENDOR'S PROPOSAL**.**

The original and duplicate copies of a Vendor's proposal must be received by the Issuing Officer at the address provided in Section 10.3 no later than the time and date specified in

Section 20.1, RFP Timetable, of this RFP. The original will be date- and time-stamped when received by the Issuing Officer.

PROPOSALS RECEIVED AFTER THE SPECIFIED TIME AND DATE WILL NOT BE CONSIDERED AND RETURNED UNOPENED.

All proposals received by the date and time specified in Section 20.1 become the property of the State of Florida and shall be a matter of record subject to the provisions of Chapter 119, Florida Statutes. The State of Florida shall have the right to use all ideas, or adaptations of the ideas, contained in any proposal received in response to this RFP. Selection or rejection of the proposal shall not affect this right.

20.14 Trade Secrets

The State of Florida is unable to ensure the confidentiality of trade secrets except to the extent provided in Chapter 119, Florida Statutes. If the Vendor submits information that is considered a trade secret, such information shall be clearly labeled as follows: "This information constitutes a trade secret under Section 812.081, Florida Statutes."

20.15 Withdrawal of Proposal

Requests for withdrawal of a proposal may be considered by the Agency if such request is received in writing within 72 hours after the Technical Proposal opening time and date. Requests received in accordance with this provision may be granted by the Agency upon proof of the impossibility to perform based upon an obvious error on the part of the Vendor. Such request is to be submitted in writing to the Issuing Officer at the address specified in Section 10.3 of this RFP. If a request for withdrawal is not received, a Vendor shall be legally responsible for fulfilling all requirements of its proposal if a contract is offered.

20.16 Public Opening of Proposals

Proposals shall be publicly opened at the time, date and location specified in Section 20.1 of this RFP. Proposals received pursuant to this RFP are exempt from the public inspection provisions of s. 119.07(1), Florida Statutes, until such time as the Agency provides notice of a decision or intended decision, or within ten (10) days after the opening of proposals, whichever is earlier.

Any person attending the public opening that requires a special accommodation because of a disability should contact the Issuing Officer at least five (5) workdays prior to the solicitation opening. If you are hearing or speech impaired, please contact the Issuing Officer using the Florida Relay Service at (800) 955-8771 (TDD).

20.17 Correction of Proposal Errors

If the Agency determines that a proposal contains a minor irregularity or an error, such as a transposition, extension or footing error in figures that are presented, the Agency may provide the Vendor an opportunity to correct the error. Information that is required to be included in the proposal and is inadvertently omitted shall not be accepted under this error correction provision. All information required to be included in a proposal must be received by the date and time that proposals are due to the Agency. The Agency reserves the right to seek clarification from a Vendor of any information contained in the proposal.

Minor irregularities in proposals may be waived by the evaluators. A minor irregularity is a variation from the RFP terms and conditions that does not affect the price of the proposal or give one applicant an advantage or benefit not enjoyed by others or adversely affects the State's interest.

20.18 Rejection of Proposals

Proposals that do not conform to the mandatory requirements of this RFP shall be rejected by the Agency. Proposals may be rejected for reasons that are provided in Appendix M, Checklist of Mandatory Items; for failure to comply with any requirement of this RFP; when the proposal is conditional; or when in the Agency discretion, it is in the best interests of the Agency. The Agency reserves the right to reject any and all proposals.

20.19 Posting of Notice of Intent to Award

Notice of an intent to award a contract will be posted at the anticipated date, time, and at the location specified in Section 20.1, RFP Timetable, and will remain posted for a period of 72 hours.

If the notice of award is delayed, in lieu of posting the notice of intended award the Agency shall post a notice of the delay and a revised date for posting the notice of intended award. Any person who is adversely affected by the decision shall file a notice of protest with the Issuing Officer within 72 hours after the electronic posting. The Agency shall not provide tabulations or notices of award by telephone.

20.20 Resolution of Protest

State procurement law and administrative procedures govern the resolution of any protest resulting from this procurement. Final contactor negotiations cannot proceed with the winning intended Contractor until any protests have been resolved.

20.21 MyFlorida Marketplace Vendor Registration

Each Vendor doing business with the State of Florida for the sale of commodities or contractual services as defined in section 287.012, Florida Statutes, shall register in MyFlorida MarketPlace, in compliance with Rule 60A-1.030, Florida Administrative Code, unless exempt under Rule 60A-1.030(3) Florida Administrative Code.

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30 CONTRACT TERMS AND CONDITIONS

30.1 General

The resulting contract between the State of Florida and the Contractor will consist of: (1) the State standard contract (Attachment A); (2) the RFP and any addenda thereto; (3) the Contractor's proposal submitted in response to the RFP; (4) the RFP questions and answers; and, (5) the transcripts of the oral presentations. In the event of a conflict in language between the documents referenced above, the provisions and requirements set forth and/or referenced in the RFP or addenda as a result of questions and answers will govern. In the event that an issue is addressed in one document that is not addressed in another document or documents, no conflict in language will be deemed to occur due to lack of reference.

No modification or change of any provision in the contract will be made, or construed to have been made, unless such modification is mutually agreed to in writing by the Contractor and the State, and incorporated as a written amendment or change order to the contract and processed through and approved by the State prior to the effective date of such modification or change.

The resulting contract that shall serve as the agreement between the parties is provided as Attachment A of this RFP. The contract shall be a fixed price contract payable from Medicaid funds appropriated in the FY (fiscal year) General Appropriations Act.

30.2 Legal Considerations

The resulting contract will be construed according to the laws of the State of Florida. Any proposal protest proceeding against the State arising out of this RFP will be brought in accordance with Chapter 120, Florida Statutes. Any other proceedings against the State related to or arising out of the contract or contractual relation will be brought in a court of competent jurisdiction. Venue for such court proceedings will lie exclusively in Leon County, Florida. The contract is subject to the provisions of Chapter 287, Florida Statutes, Rule 60A-I and Rule 28-110, Florida Administrative Code, as well as all other applicable State and federal laws and regulations.

30.3 Entire Agreement

This resulting contract will represent the entire agreement between the parties with respect to the subject matter hereof and will supersede all prior negotiations, representations or agreements, either written or oral, between the parties hereto relating to the subject matter hereof and will be independent of and have no effect upon any other contracts.

30.4 Partnering for Success

The State acknowledges the business relationship between AHCA and the Contractor selected in this procurement process. The joint goal of both the State and the Contractor must be the successful operation of the Florida Medicaid program as set forth by the State of Florida. The State and the Contractor must communicate quickly, directly and openly on all issues that may affect the success of the program. The State and the Contractor must work quickly and in good faith to resolve all disputes arising under this agreement.

30.5 Acknowledgement of the Relationship between the State and the Contractor

The State acknowledges the Contractor as its Medicaid fiscal agent for the duration of the Operations Phase of the contract. In no way will the Contractor represent itself directly or by inference as a representative of the Florida Medicaid program except within the confines of its role as fiscal agent.

The Contractor may use the State of Florida as a reference in solicitations of similar work in other States, and the State will honestly and candidly report the requirements of the Contractor and the State's level of satisfaction with the Contractor's performance in meeting those requirements. The Contractor must receive State approval for referencing the State of Florida in any advertising or for any other use. State approval must be received in all instances in which the Contractor distributes publications to the Florida Medicaid provider community.

30.6 Contract Variations

If any provision of the contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both the State and the Contractor will be relieved of all obligations arising under such provision; if the remainder of the contract is capable of performance, it will not be affected by such declaration or finding and will be fully performed.

30.7 Contract Execution and Authorization to Begin Work

The State will issue a formal letter authorizing the Contractor to begin work. The Contractor may not charge the State or bill for any work completed prior to receipt of the Authorization to Begin Work.

30.8 Term of Contract

The term of the contract begins the day the contract is executed (signed and dated) by both parties and will terminate on June 30, 2012, unless the State exercises an option to extend the contract pursuant to the provisions below. The term of the contract is expected to include a Design, Development, Planning, Testing, and Implementation Phase of up to twenty-one (21) months and a base operational period of five (5) years. The State will not renew the resulting contract.

At its sole option, the state of Florida may extend the contract for a six (6) month period, or any portion thereof, under the same terms and conditions as the original contract. The State will give the Contractor at least six (6) months prior notification if the state chooses to exercise this option to extend the contract.

The contract shall begin on the date shown in the RFP Timetable Section 20.1 or the date executed by both parties, whichever is later. Upon receipt of the Authorization to Begin Work, the Contractor shall begin the preparatory activities necessary to fulfill all obligations under the contract.

30.9 Termination of Contract

The contract resulting from this RFP will be subject to the following termination provisions. The contract may be terminated by the State:

1. For default;
2. For convenience;
3. For Contractor bankruptcy; and
4. For unavailability of funds.

30.9.1 Termination for Default

The State may terminate this contract whenever the State determines that the Contractor or subcontractor has failed to satisfactorily perform its contracted duties and responsibilities and is unable to correct such failure within a period of time specified by the State, taking into consideration the gravity and nature of the default. Such termination will be referred to herein as "termination for default".

Upon determination by the State of any such failure to satisfactorily perform its contracted duties and responsibilities, the State will notify the Contractor of the failure and establish a reasonable time period in which to correct such failure. If the Contractor is unable to cure the failure within the specified time period, the State will notify the Contractor that the contract has been terminated for default. Such notices will be in writing and delivered to the Contractor by certified mail, return receipt requested.

If, after Notice of Termination for default, it is determined by the State or a court of competent jurisdiction as created by Article V of the Florida Constitution that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control and without the error or negligence of the Contractor or any subcontractor, the Notice of Termination will be deemed to have been issued as a termination for the convenience of the State, and the rights and obligations of the parties will be governed accordingly.

In the event of termination for default the State may procure, upon such terms and in such manner as the State may deem appropriate, supplies or services similar to those terminated, and the Contractor will be liable to the State for any excess costs for such similar services for the remainder of the contract period. In addition, the Contractor will be liable to the State for administrative costs incurred by the State in procuring such similar supplies or services.

The rights and remedies of the State provided in this section will not be exclusive and are in addition to any other rights and remedies provided by law, equity, or under the contract.

30.9.2 Termination for Convenience

The State may terminate performance of work under the contract whenever, for any reason, the State will determine that such termination is in the best interest of the State. In the event that the State elects to terminate the contract pursuant to this provision, it will notify the Contractor by certified mail, return receipt requested. The contract may be terminated upon no less than thirty (30) calendar days notice, unless both parties mutually agree upon a lesser time.

30.9.3 Termination for Contractor Bankruptcy

In the event that the Contractor will 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 will 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 the event the State elects to terminate the contract under this provision, it will do so by sending Notice of Termination to the Contractor by certified mail, return receipt requested. The date of termination will be the close of business on the date specified in such notice to the Contractor, unless otherwise specified. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor, the Contractor will immediately so advise the State. The Contractor will ensure that all tasks related to the subcontract are performed in accordance with the terms of this contract.

30.9.4 Termination for Unavailability of Funds

In the event that federal or State funds for the contract become unavailable or reduced to any extent, the State will have the right to terminate the contract in whole or in part without penalty with less than twenty-four (24) hours notice, in writing, to the Contractor. Availability of funds will be determined at the sole discretion of the State. The State of Florida's performance and obligation to pay under this contract is contingent upon an annual appropriation by the legislature.

30.9.5 Procedure on Termination

Upon delivery by certified mail, returned receipt requested to the Contractor of a Notice of Termination specifying the nature of the termination, the extent to which performance of work under the contract is terminated, and the date upon which such termination becomes effective, the Contractor will:

1. Stop work under the contract on the date and to the extent specified in the Notice of Termination;
2. Place no further orders or subcontracts for materials, services, or facilities, except as may be necessary for completion of such portion of the work under the contract as is not terminated;
3. Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the Notice of Termination;
4. Assign to the State in the manner and to the extent directed by the Contract Manager all of the rights, title, and interest of the Contractor under the orders or subcontracts so terminated, in which case the State will have the right, in its discretion, to settle or pay any or all claims arising out of the termination of such orders;
5. With the approval or ratification of the Contract Manager, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, the cost of which would be reimbursable, in whole or in part, in accordance with the provision of the contract;
6. Within ten (10) workdays from the effective date of termination, transfer title to the State (to the extent that title has not already been transferred) and deliver in the manner, at the times, and extent directed by the Contract Manager all files, processing systems (excluding equipment and operating systems), data manuals, or

other documentation, in any form, that relate to the work terminated by the Notice of Termination;

7. Complete the performance of such part of the work as will not have been terminated by the Notice of Termination;
8. Take such action as may be necessary, or as the Contract Manager may direct, for the protection and preservation of the property related to the contract which is in the possession of the Contractor and in which the State has or may acquire an interest; and
9. Complete each and every portion of the Turnover Phase (Section 50) after receipt of the Notice of Termination.

The Contractor will 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.

30.9.6 Termination Claims

After receipt of a Notice of Termination, the Contractor will submit to the Contract Manager any termination claim in the form and with the certification prescribed by the Contract Manager. Such claim will be submitted promptly but in no event later than one (1) year from the effective date of termination, unless one or more extensions in writing are granted by the Contract Manager within such one (1) year period or authorized extension thereof. However, if the Contract Manager determines that the facts justify such action, he may receive and act upon any such termination claim at any time after such one (1) year period or any extension thereof. Upon failure of the Contractor to submit its termination claim within the time allowed, the Contract Manager may, subject to any review required by the State procedures in effect as of the date of execution of the contract, determine, on the basis of information available to him, the amount, if any, due to the Contractor by reason of the termination and will thereupon cause to be paid to the Contractor the amount so determined.

Upon contract termination, the Contractor will be paid only the following:

1. At the contract price(s) for completed deliverables and services delivered to and accepted by the State.
2. At a reasonable price mutually agreed to by the Contractor and the State for partially completed deliverables.

The Contractor will have no entitlement to receive any amount for anticipated future profits associated with this contract.

In the event of the failure of the Contractor and the State to agree in whole or in part as to the reasonable price to be paid to the Contractor in connection with the total or partial termination of work pursuant to this article, the State will determine a reasonable price, and will pay to the Contractor the amount so determined.

30.10 Notices

Whenever under this contract one party is required to give notice to the other, such notice will be hand delivered, or registered or certified mail return receipt requested and will be deemed to have been delivered on the day of delivery if delivered by hand (with dated receipt being obtained) or the actual date delivered as indicated on the return receipt if sent

by registered or certified mail, except that if no such date is indicated then it will be presumed to have been delivered three workdays after posting. Notices will be addressed as follows:

In case of notice to the Contractor:
FMMIS Account Manager
Street Address
Tallahassee, Florida

In case of notice to the State:
Alan Levine
Secretary, Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 1
Tallahassee, Florida, 32308

30.11 Federal Certification

The Contractor is responsible for creating a MMIS that meets all requirements for federal certification and qualifies for the maximum Federal Financial Participation (FFP) within six (6) months of the beginning of the Operations Phase. During the certification process, the Contractor will make any changes required by the federal government for certification expediently and without additional charge to the State.

30.12 Funding Source

This contract is funded with State and federal (Title XIX and Title XXI) funds. The amounts and percentages are derived from the State's cost allocation plan, subject to CMS approval.

30.13 Cost Allocation Plan

Sixty (60) calendar days after the receipt of the Authorization to Begin Work, the Contractor will develop a cost allocation plan that properly identifies all costs under the contract by category of Federal Financial Participation (FFP) and provides documentation to support the State's claim for Federal Financial Participation (FFP) in accordance with State Medicaid Manual, Part 11. The State will utilize the Contractor's cost allocation plan in conjunction with Medicaid's cost allocation data to prepare Florida's Medicaid cost allocation plan and submit to CMS for approval. The Contractor is responsible to produce monthly reports to account for categories of expenditure to the federal government. The Contractor is expected to automate more of the administrative and operational processes, thus increasing the State's overall FFP rate.

30.14 Prime Contractor

Any contracts that may result from the RFP will specify that the Prime Contractor is responsible for fulfillment of the contract with the State. The Prime Contractor will be designated in the proposal and will have the overall responsibility for every requirement in the RFP, including the work of the subcontractor. The use of subcontractors must be clearly explained in the proposal. Any subcontracts that result from this RFP will not relieve the Prime Contractor from its responsibility for the fulfillment of every requirement.

30.15 Subcontractors

The Contractor may subcontract work required by a contract resulting from this RFP. Subcontracts, however, must be approved by the Agency prior to execution by the Contractor and the commencement of work by a subcontractor.

The Contractor may, with the consent of the State, enter into written subcontract(s) for performance of certain of its functions under the contract. The subcontractors and the amount of the subcontract will be identified in the Contractor's response to this RFP. A copy of all the subcontracts shall be provided to the State prior to subcontract execution. The State's Contract Manager must approve subcontracts in writing prior to the effective date of any subcontract.

Any subcontract changes subsequent to the Contractor's response to this RFP, constitutes a change in the approved subcontractor. Changes in subcontractor require approval in writing by the State's Contract Manager prior to the effective date of any subcontract.

The Contractor shall be responsible for monitoring the subcontractor's performance. The results of the monitoring shall be provided to the Agency's Contract Manager, fourteen (14) workdays after the end of each month or as specified by the Agency. If the subcontractor's performance does not meet the State's performance standard according to the monitoring report, a corrective action plan must be submitted to the Prime Contractor and the State within fourteen (14) workdays of the deficient report.

No subcontract which the Contractor enters into with respect to performance under the contract resulting from this RFP will in any way relieve the Contractor from its responsibility for the fulfillment of every requirement. All payments to subcontractors will be made by the Prime Contractor.

30.16 Transparency of Subcontractor Relationships

The Contractor must make its subcontractor agreements available to the State upon request. For any subcontract, there must be a designated project manager, who is a member of the subcontractor's staff that is directly accessible by the State. This individual's name and contact information must be provided to the State when the subcontract is executed. The State reserves the right to act as binding arbiter in any dispute between the Contractor and its subcontractors that may negatively impact operation of the Florida Medicaid program. In the application of actual and liquidated damages under this contract, the State reserves the right to allocate the percentages of actual and liquidated damages that apply to the Contractor and to the subcontractor.

30.17 Cost or Pricing Data for Subcontractors

The Contractor will submit and will require subcontractors hereunder to submit cost or pricing data under the following circumstances:

1. Prior to the award of any subcontract;
2. Prior to the execution of any contract or subcontract, extension, or renewal which involves aggregate increases or decreases in cost over the contract or subcontract's term; except where the price is based on adequate price competition, established catalog or market prices of commercial items sold in substantial quantities to the general public, or prices set by law or regulation; however, the State may request cost of pricing data for this as well;

3. The Contractor will certify and will require subcontractors to certify in a form satisfactory to the State that, to the best of their knowledge and belief, the cost or pricing data submitted under this section is accurate, complete, and current as of the date of agreement on the negotiated price of the subcontract or of the contract or subcontract change;
4. The Contractor will insert the substance of this Section, including this paragraph, in each subcontract; and
5. If the Agency's Contract Manager determines that any price, including the administrative fee, negotiated in connection with this contract, or any pass-through under this contract was increased by any sums because the Contractor or any subcontractor furnished incomplete or inaccurate cost or pricing data not current as certified in the Contractor's or subcontractor's certification of current cost or pricing data, then such price or cost will be reduced accordingly and this agreement and the subcontract, if applicable, will be modified in writing to reflect such reduction.

30.18 Assignment

The Contractor will not assign the contract in whole or in part without the prior written consent of the Agency's Contract Manager. Any assignment for which consent is given will be subject to the conditions of this contract and any other conditions of approval deemed necessary by the State. Any purported assignment is void. However, the State will 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 Florida, upon giving prior written notice to the Contractor.

30.19 State Ownership

The Agency shall have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Contractor as a result of the contract.

Title to the complete system will be transferred to the State, including portions (e.g., documentation) as they are created during the Design, Development and Implementation Phases or as they are used in the operation of the system, including any and all performance-enhancing software and operational plans whether developed or obtained by the contract or before it. This obligation to transfer all ownership rights and/or license on the part of the Contractor is not subject to limitation in any respect whether by characterization of any part of the system as proprietary or by failure to claim for the cost thereof.

The Contractor will convey to the State copies of system documentation, operating instructions and procedures, and all data processing programs or portions thereof, on the media specified by the State, to the extent that such programs are requested by the State and are developed by the employees of the Contractor or any subcontractor as part of the contract.

The Contractor will not develop or install any proprietary software for operation of the FMMIS/DSS without prior approval from the State. Installation of any commercial packages must also be prior approved by the State. The State may allow the development and installation of proprietary software if considered in the best interest of the State and if the Contractor is willing to provide the State the rights and/or license to operate and maintain the software in question, after the termination of the contract. No proprietary

software/systems may be implemented, using FMMIS/DSS data, unless prior approved in writing by the State.

30.20 Contract Amendments

Any portion of this contract may be amended through mutual agreement in writing. The State may request the Contractor's staff to make improvements and modifications directly related to the fiscal agent services sought by this procurement that are not specifically covered in this RFP. Modifications requiring additional personnel, equipment, office space or services that cannot be performed by existing staff will require a written contract amendment as appropriate. Executed contract amendments will be considered to be an integral part of the contract.

The Contractor must expeditiously estimate and substantiate any price changes to the system that require a contract amendment. Prices for any amendment must be based on actual work effort, cost of materials and cost of subcontractors. Work prices must conform to the amount recorded on the appropriate Schedule C1 through C6 for each class of employee for the corresponding year of the amendment.

The CMS Regional Office must approve all amendments to the contract before they are executed by the State and the Contractor.

30.21 Employment of State Workers

In fulfilling the terms of the contract, the Contractor shall not employ, subcontract with, or sub-grant to any person who is or has been at any time during the period of this contract in the employment of the Agency for Health Care Administration, except regularly retired employees, or adversely affected State employees, without prior written approval of the State's Contract Manager. Further, the Contractor will not knowingly engage in this project, on a full-time, part-time, or other basis during the period of this contract, any former employee of the State where such employment conflicts with Section 112.3185, Florida Statutes). Failure to comply with this provision shall render the contract void at the option of the State with no compensation for services already rendered under the contract.

30.22 Contractor Personnel

The Contractor will warrant that all persons assigned to the performance of this contract will be employees of the Contractor (or specified subcontractor) and will be fully qualified to perform the work required herein. The Contractor will include a similar provision in any contract with any subcontractor selected to perform work hereunder. The minimum staff level specified in Section 50.2 must be maintained for the life of the contract.

30.22.1 Approval of Staff

The State reserves the right to approve or disapprove any of the Contractor's proposed changes in staff, or to require the removal or reassignment of any Contractor employee or subcontractor employee found unacceptable by the State. The Contractor will, upon request, provide the State with a resume of any member of its staff or a subcontractor's staff assigned to or proposed to be assigned to perform any part of this contract.

The Named Staff identified by resume in the proposal submitted by the Vendor may, at the option of the Agency, be interviewed by the Agency as part of the evaluation

process. All personnel to be used by the Contractor, including Named Staff, are subject to the State's right to remove staff deemed unacceptable by the State.

30.22.2 Personnel Commitments

Personnel commitments made in the Contractor's proposal will not be changed except as provided in this section or due to a resignation. All staff, assigned to this contract, will be solely dedicated to Florida and may not be assigned to work on other contracts or accounts during the contract period. Contractor staffing will include the individuals at the levels of effort proposed in the Contractor's Technical Proposal.

The Contractor must notify the State within five (5) workdays of any decision to terminate or transfer Named Staff. The State must prior approve, in advance, in writing, any changes to the Contractor's Named Staff. Named Staff are those staff defined in Section 50. The Contractor will be required to submit justification of any Named Staff changes, including proposed substitution, in sufficient detail, to permit evaluation of the impact on the Florida Medicaid operations. Replacement of any personnel will be with personnel of equal ability and qualifications as determined by the State. No diversion in staffing will be made by the Contractor without prior written consent of the State.

30.22.3 Nondiscrimination

The Contractor will not discriminate against any employee or applicant for employment because of age, sex, race, creed, color, national origin, handicap, or political affiliation. The Contractor will take affirmative action to ensure that applicants for employment and employees are treated without regard to their age, sex, race, creed, color, national origin, handicap, or political affiliation. Such action will include, but is not limited to the following: employing, upgrading, demotion or transfer; recruitment or recruitment advertising; layoffs or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship.

The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

30.23 Independent Contractor

It is expressly agreed that the Contractor and any subcontractors and agents, officers, and employees of the Contractor or any subcontractor in the performance of this contract will act in an independent capacity in the performance of this contract and not as officers, employees, or agents of the State.

30.24 Performance Bond

The Contractor shall furnish to the Agency a performance bond in the amount of 15% of the average five-year annual operational cost. The bond shall be written by a surety company authorized to do business in the State of Florida and signed by a Florida Licensed Agent. If a non-resident Florida Licensed Agent signs the bond, the bond shall be considered to have been made and executed in the State of Florida. The bond will be furnished to the Agency's Contract Manager within 30 calendar days after execution of the contract and prior to commencement of any work under this contract. No payments will be made to the Contractor until the performance bond is in place and approved by the Agency in writing. The performance bond shall remain in effect for the full term of the contract, including any

extension. The Agency shall be named as the beneficiary of the Contractor's bond. The bond shall provide that the insurer or bonding company(ies) shall pay losses suffered by the Agency directly to the Agency.

The cost of the performance bond will be borne by the Contractor. The bond will be accompanied by a duly authenticated or certified document, in duplicate, evidencing that the person executing the bond on behalf of the surety company is a licensed Florida agent for the bonding company. In every case, the conferring of that authority must have occurred prior to the date of the bond, and the document showing the date of appointment and enumeration of powers of the person executing the bond must be accompanied by a certification that the appointment and powers have not been revoked and remain in effect. The date of that certification will be dated the same as the bond.

Should the Contractor terminate the contract prior to the end of the contract period, an assessment against the bond will be made by the State to cover the costs of continuing operations, issuing a new RFP, and selecting a new Contractor.

30.25 Contractor's Maintenance of Insurance

The Contractor will not commence any work in connection with the contract until it has obtained all of the following types of insurance and such insurance has been approved by the State, nor will the Contractor allow any subcontractor to commence work on a subcontract until all similar insurance required of the subcontractor has been so obtained and approved. All insurance policies will be with insurers qualified and doing business in Florida. This insurance will be in a form and issued by an insurer acceptable to the State. Copies of all policies together with all schedules will be sent to the State within thirty (30) calendar days of the date of execution of the contract, and prior to commencement of any work under the contract.

30.25.1 Workers' Compensation Insurance

The Contractor will secure and maintain during the life of the contract, worker's compensation insurance for all of its employees connected with the work of this project and, in case any work is subcontracted, the contract will require the subcontractor similarly to provide workers' compensation insurance for all of the latter's employees unless such employees are covered by the protection afforded by the Contractor. Such insurance will comply fully with Florida's Workers' Compensation Act. In case any class of employees engaged in hazardous work under this contract at the site of the project is not protected under the Workers' Compensation Act, the Contractor will provide, or cause each subcontractor to provide, adequate insurance satisfactory to the State for protection of its employees not otherwise protected. Proof of insurance will be provided within thirty (30) consecutive calendar days after the execution of the contract and prior to commencement of any work under the contract (including name of the insurance company, amount of coverage, effective date, ending period, and policy number).

30.25.2 Contractor's Public Liability and Property Damage Insurance

The Contractor will take out and maintain during the life of this contract, comprehensive general liability and comprehensive automobile liability insurance that will protect the Contractor from claims for damage for personal injury, including accidental death, as well as agreement whether such operations are by itself or by anyone directly or indirectly employed by the Contractor, and the amount of such insurance will be the minimum limits as follows:

1. Contractor's comprehensive general liability coverage, bodily injury & property damage, $1,000,000 each accident;
2. Automobile liability coverage, bodily injury, $1,000,000 each accident; and
3. Automobile liability coverage, property damage, $500,000 each accident.

The insuring clause for both bodily injury and property damage will be amended to provide coverage on an occurrence basis.

30.25.3 Subcontractor's Public Liability and Property Damage Insurance

The Contractor will require each of its subcontractors to secure and maintain during the life of the subcontract, insurance of the type specified above or alternatively, will insure the activities of its subcontractors in its policy.

30.25.4 Loss Deductible Clause

The State will be exempt from, and in no way liable for, any sums of money, which may represent a deductible in any insurance policy. The payment of such deductible will be the sole responsibility of the Contractor or subcontractor providing such insurance.

30.26 Contract Billing and Payment

The Contractor shall be paid upon satisfactory completion and State approval of milestones or phases as designated in the RFP and contract. The Contractor will be paid through an invoice submitted to the State.

30.27 Method of Payment

30.27.1 Procurement Phase

Activities under the Procurement Phase are described in Section 20. The Contractor may not charge the State for any of its activities as part of the Procurement Phase.

30.27.2 FMMIS/DSS Planning, Design, Development, Testing and Implementation Phases

The Contractor shall be paid upon State acceptance and approval of the Contractor's completion of selected milestones or phases. The FMMIS/DSS Planning, Design, Development, Testing and Implementation Phases include all of the activities reflected on the Pricing Schedule B-1.

Pricing Schedule B-1 – Net Present Value FMMIS/DSS Planning, Design, Development, Testing and Implementation Price:

This schedule includes all activities required to plan, design, develop, test, and implement the new system. Payment will be made for the total price of this schedule upon completion of the milestones or phases indicated in the schedule at the percentages indicated below:

Design and Development Phase	
December 2005	Planning (4%)
February 2006	Requirements Analysis (3%)
May 2006	Business and Technical Design (4%)
July 2006	Comprehensive Testing Plan (10%)
February 2007	Development of New System (35%)
June 2007	Acceptance Testing (10%)
Implementation Planning Phase	
December 2005	Planning (4%)
February 2006	Requirements Analysis (3%)
May 2006	Business and Technical Design (4%)
July 2006	Comprehensive Testing Plan (10%)
June 2007	Acceptance Testing (3%)
Implementation Phase	
September 2007	Corrections and Adjustment Activities (10%)

The total amount paid for all FMMIS/DSS Planning, Design, Development, Testing and Implementation Phases will not exceed $40,000,000.

The Agency shall withhold 10% from each payment in Schedule B. The payment withholds shall be released following the one year warranty period based upon approval of the system by the State and certification of the system by CMS.

30.27.3 Operations Phase

Payment for the Operations Phase will be made as follows:

1. Fixed price per month;
2. Should the average members per month exceed 3.0 million for any given month, the State shall pay the Contractor an additional $1.25 for each member that exceeds 3.0 million; and
3. Payment for “Pass Through” items.

Actual expenditures for pass-through items made on the State’s behalf will be reimbursed without profit or overhead. The cost of pass-through items is not included in the fixed price per month. Items designated as pass-through items include, but are not limited to:

State Owned Equipment	$7,000,000
Postage	Actual Cost
Printing	Actual Cost
Communication lines to Medicaid Contract Management	Actual Cost
Administrative fee paid to the Contractor for amendments for temporary resources obtained through subcontracts	This administrative fee will be 3% of the amendment cost, not to exceed $150,000.

State owned equipment to be procured as a pass-through cost is listed in Appendix G. The specifications for and the quantity of the equipment will be adjusted as necessary at

the time of equipment procurement to ensure that the total cost does not exceed the amount listed above.

30.27.4 MITA Gap Analysis Phase

The Contractor shall be paid based upon State acceptance and approval of the MITA Gap Analysis Phase as defined Section 50.

The payment will be made at the firm fixed price listed in Pricing Schedule D.

30.27.5 Electronic Health Records Phase

The Contractor shall be paid based upon State acceptance and final approval of the Electronic Health Record Phase as defined in Section 50. The Contractor shall agree to modify or correct all computer code developed during this phase, for a period of one (1) year from the date of State approval. Ten percent (10%) of the payment for this phase will be withheld until the end of warranty period.

The payment will be made at the firm fixed price listed in Pricing Schedule E.

30.27.6 Payments for System Modifications

The Contractor must maintain a staff of managers, business analysts, database administrators, programmers and system operators as described in Section 50.2 for the purpose of modifying FMMIS/DSS to meet changing requirements. The Contractor may not charge for the work of this staff; all such work shall be completed based on priorities set by the State. Modifications requiring more than 15 person days of work fall under the requirements of Section 50.

No additional or separate payment will be made by the State for the cost of computer resources or other items necessary for system modifications. Payment for such services will be encompassed in the fixed price per month.

30.27.6.1 System Fixes Related to Contractor Error

The Contractor must dedicate additional resources at its own expense, not from the pool of staff allocated to system modifications and modernization, to fix FMMIS/DSS and to reprocess any batches or claims due to an error in design or operation of FMMIS/DSS.

No additional or separate payment will be made by the State for the cost of computer resources or other items necessary for system modifications due to error. Payment for such services will be encompassed in the fixed price per month.

30.27.6.2 System Fixes Necessary for Continued System Operation

In the case of any interruption in critical functions of FMMIS/DSS operation, including eligibility verification, claims processing and claims payment, the Contractor must, at its own expense, dedicate all resources necessary to immediately fix FMMIS/DSS and restore full operation.

No additional or separate payment will be made by the State for the cost of computer resources or other items necessary for fixes necessary for continued system operation. Payment for such services will be encompassed in the fixed price per month.

30.27.6.3 Continuing System Modernization

The Contractor must maintain a staff of managers business analysts, database administrators, programmers and system operators as described in Section 50.2 for the purpose of modernizing FMMIS/DSS to improve operation efficiency. The staff is the same as identified in Section 50. The Contractor may not charge for the work of this staff; all such work shall be completed based on priorities set by the State. Modifications requiring more than fifteen (15) person days of work fall under the requirements of Section 50.

No additional or separate payment will be made by the State for the cost of computer resources or other items necessary for system modernization. Payment for such services will be encompassed in the fixed price per month.

30.27.7 Turnover Phase

No additional or separate payment will be made by the State for the Turnover Phase. Payment for such services will be encompassed in the fixed price per month based on the appropriate Schedule C.

30.27.8 Final Invoice for FMMIS/DSS Planning, Design, Development, Testing and Implementation Tasks

The Contractor will submit the final invoice for payment to the State no more than forty-five (45) calendar days after acceptance of the final implementation deliverable by the State. If the Contractor fails to do so, all right to payment is forfeited, and the State will not honor any request submitted after aforesaid time period unless approved in writing by the Agency's Contract Manager.

30.28 System Warranty

The Contractor shall warrant that the system meets the CMS certification requirements, the contract requirements as defined in the RFP, the design and development documents, and the system documentation for one (1) year from the beginning of the Operation Phase.

The Contractor shall agree to modify or correct all computer code developed under this contract, for a period of one (1) year from the day the operations begins. The Contractor will document the system functions as defined in Section 50 utilizing the Performance Reporting System during the warranty period.

Payments withheld during the Planning, Design, Development, Testing and Implementation Phases will be released upon State approval and acceptance that the system meets all requirements. The Contractor will forfeit the payment withholds for failure to meet the requirements by the end of the warranty period.

30.29 Performance Monitoring

The State will monitor the Contractor's performance using a Performance Reporting System. The State believes that this is the most effective way to monitor the quality of the Contractor's performance, document performance levels in all critical areas of the system, facilitate the management of the fiscal agent contract and enhance the investment made by the State and federal government in the administration of the Medicaid program.

1. The State will identify areas of Contractor performance where quality is critical to the mission of the Medicaid program.

2. During contract implementation, the State will reach agreement with the Contractor concerning the levels of quality that are desirable, acceptable and substandard for each area. The State and Contractor will develop means to measure those quality levels on a monthly basis, using the Performance Reporting System.
3. The Contractor will provide an automated method for FMMIS/DSS and other system/operations tools used to provide the monthly reports of the quality measurements agreed upon by the State and the Contractor at no additional programming cost to the State.
4. The automated reports will be flexible and adaptable to changes in the quality measurements as agreed upon by the State and Contractor during the Operations Phase through a rules-based engine, or component of a rules-based engine, in the FMMIS/DSS.
5. During the course of the contract, the Contractor will measure performance using the Performance Reporting System. State contract management staff will actively participate with the Contractor in the performance reporting process and will approve the results recorded.
6. Quality measurements will be reviewed by the State and the Contractor on a quarterly basis to access any measurements that should be changed, added or deleted for the next reporting period.
7. At the end of each reporting period, the Performance Reporting System results will be posted on the public Web portal.
8. An independent, accredited auditing firm will review all audit reports on an annual basis.

Each performance measure will have its own scoring mechanism established through negotiation with the Contractor and the State and will consist of scoring elements totaling one hundred (100) points. For each of the performance measures, the number of points scored will determine a quality scorer, as follows:

1. 94 to 100 points = Significantly Exceeds Contract Requirement
2. 86 to 93 points = Exceeds Contract Requirement
3. 78 to 85 points = Meets Contract Requirement
4. 70 to 77 points = Partially Meets Contract Requirement
5. Below 70 points = Does Not Meet Contract Requirement

A corrective action will be required for performance measures that score 77 or below.

Liquidated and actual damages will be assessed for performance measures that score 77 or below.

The copies of report cards that were used to measure performance in the current contract are available for review in the Medicaid Procurement Library.

30.30 Record Retention Requirements

The Contractor will agree to the following terms for retention and access to records relating to the contract:

1. All original paper claims adjudicated under the contract will be retained for a minimum of ninety (90) calendar days from date of payment or denial. Upon State acceptance of the

optical image or micromedia copy, and upon receipt of written approval from the State, original claims may be destroyed after the ninety (90) day period in accordance with State and federal guidelines; copies of all claims and related records in optical image, or on micromedia will be retained for the duration of the contract period after which the Contractor will, at State direction, either destroy or transfer the copies to the State. At the end of the contract, copies of all claims and any related records in the custody of the Contractor will, at State direction, be either destroyed or transferred to the State;

2. Unless the State specifies in writing a shorter period of time, the Contractor agrees to preserve and make available all other pertinent books, documents, papers, and records (including electronic storage media) of the Contractor involving transactions related to the contract for a period of seven (7) years from the date of expiration or termination of the contract;
3. All original canceled checks will be retained for a minimum of seven (7) years from the date of issue unless otherwise notified by the State; storage will be in the State of Florida, Leon County, throughout this period. Upon expiration or termination of this contract, all retained canceled checks will be transferred to the State;
4. Records, which relate to appeals, audits or litigation that have been initiated and not resolved at the end of seven (7) years, will be retained until resolution of the findings; and
5. The Contractor will agree that authorized federal and State representatives will have full access to the Contractor's facility and all records in any way related to the performance of this contract. This access will be granted during the contract period and during the seven (7) year post-contract period or until resolution. During the contract period, the access to these items will be provided at the Contractor's office in Leon County at all reasonable times. Records not required to be kept in Leon County will be made available in Leon County within two workdays and will remain available there for up to thirty (30) consecutive calendar days. During the seven (7) year post-contract period, delivery of and access to the listed items will be at no cost to the State.

30.31 Actual and Liquidated Damages

Damage may be sustained by the State in the event that the Contractor fails to meet the requirements of this contract. If the damages can be measured in actual cost, it is referred to as actual damages. If the damages are difficult to measure or cannot be measured in actual cost, it is referred to as liquidated damages. In the event of default or the inability to maintain minimum standards as determined by the State, the Contractor agrees to pay the State for the actual cost of damages or the sums set forth below as liquidated damages. Liquidated damages are considered compensation for increase contract management and do not constitute a penalty.

30.31.1 Transfer of Named Staff Proposed

30.31.1.1 Requirements

The Contractor will maintain all Named Staff proposed for each phase of the contract, and for two years from the start of Operations Phase. Only after the first two years of operations will the Contractor be allowed to request the replacement of any Named Staff, subject to prior approval of the State.

Named Staff are identified in Section 50.

30.31.1.2 Liquidated Damages

If any Named Staff are replaced without approval during any phase of the contract, or in the first two years of operations, other than at the request of the State or termination of the staff member's employment with the Contractor, liquidated damages equal to $500 per remaining workday for each Named Staff shall be assessed.

30.31.2 Named Staff Vacancy

30.31.2.1 Requirements

Positions that are designated as Named Staff shall not remain vacant for more than thirty (30) calendar days. Named Staff positions shall not be filled with employees who are acting in a temporary capacity and also maintain responsibilities for another position.

Named Staff are identified in Section 50.

30.31.2.2 Liquidated Damages

The liquidated damages will be $500 per workday for each day that the Contractor fails to meet this requirement.

30.31.3 Staffing Levels and Staffing Rate of Pay

30.31.3.1 Requirements

The Contractor will maintain the minimum number and levels of qualified staff specified in its proposal and, in all other respects meet the staffing requirements of Section 50.2 and the personnel requirements of Section 50. The Contractor will reimburse its employees according to the rate of pay in the appropriate Schedule C.

30.31.3.2 Liquidated Damages

Staffing levels and rate of pay are subject to State audit at any time during the Operations Phase of the contract. If the audit reveals staffing more than five percent (5%) below the requirement of the contract actual damages will be assessed according to the cost in the appropriate Schedule C for each FTE below the standard.

30.31.3.3 Actual Damages

The Contractor will be assessed the difference between the rate of pay for an employee and the appropriate Schedule C as determined by a payroll audit.

30.31.4 Performance Reporting System Report

30.31.4.1 Requirements

The Contractor must provide a monthly performance report produced by the Performance Reporting System in a manner acceptable to the State, as specified in Section 30.29, within fourteen (14) workdays of the end of the month.

30.31.4.2 Liquidated Damages

The liquidated damages for failure to provide the report timely or in a manner acceptable to the State will be $500 a day for each workday the report is not received or acceptable.

30.31.5 Performance Monitoring

30.31.5.1 Requirements

The Contractor is required to meet the requirements of the contract in all areas measured by the Performance Reporting System.

30.31.5.2 Liquidated Damages

The liquidated damages for performance measure areas that score below 77 will be $5,000. The liquidated damages for performance measures areas that score below 70 will be $10,000.

30.31.6 Provider Activation Prior to Meeting Eligibility Requirements

30.31.6.1 Requirements

The Contractor is responsible for enrolling providers according to the rules established by the State that include but are not limited to: licensure, background check, and site visits.

30.31.6.2 Actual Damages

The Contractor will be assessed actual damages that result from the enrollment of a provider that has not met all the enrollment requirements.

30.31.7 System Certification and Performance Review

30.31.7.1 Requirements

The Contractor will ensure that MMIS federal certification (or its equivalent) is achieved and continued throughout Operation Phase of the FMMIS by the Contractor. In the event that the CMS determines that a new certification process is necessary, the Contractor will ensure for their designated functions that all such certification requirements are met and that the new certification is retroactive to the date on which certification was discontinued should such discontinuation occur.

The Contractor is responsible for meeting any new or modified federal standards, conditions or functional requirements for the operation of the FMMIS.

The Contractor will be responsible for ensuring that federal MMIS certification and recertification requirements established by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) are met, and that maximum allowable Federal Financial Participation (FFP) is granted. Should the Contractor identify at any time any area in which certification or recertification requirements may not be met or any reason for which maximum FFP would not be granted, the Contractor will notify the State of the deficiency, present corrective action plans and upon approval by the State, correct the deficiency.

The Contractor will provide all support requested by the State during certification and any recertification conducted by CMS and by the State. The support will include assisting the State and CMS in sample selections, document and data gathering, and responding to CMS and State questions.

30.31.7.2 Actual Damages

The Contractor will be liable for the difference between the maximum allowable federal financial participation (FFP) and that actually received by the State for the operation of the FMMIS as required by certification standards that is attributable to performance or non-performance of the Contractor.

30.31.8 Systems Documentation

30.31.8.1 Requirements

The Contractor is responsible for providing to the State complete, accurate, and timely documentation of the operational FMMIS/DSS. Such documentation must be produced according to the specifications described in Section 40.1.3.12. In addition to the required hard copies, the FMMIS/DSS documentation will be maintained on the Contractor's Web portal.

Six copies of updated documentation and online documentation must be provided to the State in final form within sixty (60) workdays prior to the beginning of the operations task.

The Contractor must update documentation with all modifications and modernizations that are made to the system after the initial delivery of the documentation. Six copies of updated documentation must be provided to the State in final form within fifteen (15) workdays of the State's approval of the implementation of the change. Online documentation must be posted within three (3) workdays of the State's approval of the documentation.

30.31.8.2 Liquidated Damages

The liquidated damages will be one hundred dollars ($100) for each workday that documentation is not submitted or is unacceptable to the State.

30.31.9 Medicare Premium Liability

30.31.9.1 Requirements

The State's Medicare premium liability must be paid to CMS in accordance with U.S. Department of Health and Human Services State Buy-In Manual, Pub. 100-15, contained in the Medicaid Procurement Library.

30.31.9.2 Actual Damages

The actual damages will be equal to the charges assessed to the State by CMS in accordance with the U.S. Department of Health and Human Services State Buy-In Manual, Pub. 100-15 contained in the Medicaid Procurement Library.

30.31.10 Correctness of Payments

30.31.10.1 Requirements

All payments made through FMMIS must be made on behalf of eligible recipients, to enrolled, eligible providers, for approved services, and in accordance with the payment rules and other policies of the State.

30.31.10.2 Actual Damages

If an overpayment or duplicate payment is made to a provider or any other entity and that payment is the result of Contractor error then the Contractor will be liable for the immediate reimbursement to the State for the actual overpayment or duplicate payment. The Contractor has the right to recover such overpayments or duplicate payments.

30.31.11 Data Conversion

30.31.11.1 Requirements

The Contractor must convert all data from the State's existing MMIS and DSS necessary to operate FMMIS/DSS and produce comparative reports for previous periods of operation. Data conversion must be completed before the five-month parallel and user acceptance testing period begins, and must be applied before implementation.

30.31.11.2 Liquidated Damages

The liquidated damages will be one thousand dollars ($1,000) for each workday that data conversion is not completed or applied as stated above. Data conversion must be approved by the State before it is considered complete and before it is applied.

30.31.12 Milestones or Phases

30.31.12.1 Requirements

Unless otherwise specified, milestones and phases that occur during the Planning, Design, Development, Testing, and Implementation Phases must be completed by the Contractor in final form as required in Section 50 on the dates specified in the Contractor's work plan. The State must review and provide written acceptance of all milestones or phases.

30.31.12.2 Liquidated Damages

The liquidated damages will be one thousand dollars ($1,000) per workday for each day the milestone or phase is late or unacceptable.

30.31.13 Data Communications

30.31.13.1 Requirements

The Contractor will provide continuous twenty-four (24) hour connection to the State's network as described in Section 50. Failure to provide this connection must be remedied immediately upon notification by the State.

30.31.13.2 Liquidated Damages

The liquidated damage for failure to remedy a lack of network connection will be one thousand dollars ($1,000) per hour after four (4) hours of State notification, if lack of connection occurs as a result of Contractor error or omission.

30.31.14 EDP Audit

30.31.14.1 Requirements

The Contractor will have completed by October 1 of each year an electronic data processing (EDP) systems audit using SAS (Statement of Accounting Standards) 70.

The Contractor must respond to each SAS 70 audit with a proposed corrective action plan within thirty (30) calendar days of the audit, if necessary.

The Contractor must complete implementation of the State approved corrective action plan within forty (40) calendar days of approval unless otherwise specified by the State.

30.31.14.2 Liquidated Damages

The liquidated damages will be:

One hundred dollars ($100) per workday or any part thereof beyond October 1 of each year that the audit is not completed to the State's satisfaction;

One hundred dollars ($100) per workday or any part thereof beyond the thirty (30) calendar day requirement for submitting a corrective action plan which is satisfactory to the State; and

One hundred dollars ($100) per workday or any part thereof beyond the forty (40) calendar day requirement for implementing the corrective action plan.

30.31.15 Sponsorship

30.31.15.1 Requirements

Any publicity given to the program or services as described in Section 30, including, but not limited to, notices, information pamphlets, press releases, research, reports, signs, and similar public notices prepared by or for the Contractor will contain a statement indicating sponsorship by the Contractor and the State. The language of the statement will be specified by the State after the contract is awarded.

30.31.15.2 Liquidated Damages

The liquidated damages will be five thousand dollars ($5,000) per incident in which the State approval is not obtained.

30.31.16 Record Retention and Access Requirements

30.31.16.1 Requirements

The Contractor will maintain and will make available within three (3) workdays of request all records described in Sections 30.30 and 30.46.

30.31.16.2 Liquidated Damages

The liquidated damages will be three hundred dollars ($300) per request per work day or any part thereof for failure to produce requested records.

30.31.17 Back Up Site/Data

30.31.17.1 Requirements

In the event of a natural or man-made disaster all data/files must be protected in an off-site location. The Contractor must provide an alternate business site if the primary business site becomes unsafe or inoperable. The business site must be fully operational within five (5) workdays of the primary business becoming unsafe or inoperable. See Section 40.1 for requirements for disaster recovery and back up.

30.31.17.2 Liquidated Damages

The liquidated damages for failure to provide the back up site/data will be $10,000 per day for each day that the back up site is not fully operational.

30.31.18 System Capacity

30.31.18.1 Requirements

The Contractor must maintain the system capacity to operate FMMIS/DSS without interruption, except for scheduled down-time, and meet all operational requirements and process all claims and transactions in a timely manner. The following are indications that the system is operating below capacity:

1. Delays or interruptions in the operation of FMMIS/DSS and related services caused by inadequate equipment or processing capacity.
2. System not available for use by State or Contractor staff at all times except for scheduled downtime.
3. Inability to adjudicate to a paid, denied, or suspended status, all claims received by the Contractor within twenty-four (24) hours of receipt.
4. Frequent delays of more than five (5) seconds in screen response time.

30.31.18.2 Liquidated Damages

The State will notify the Contractor if the system is operating below capacity based on these measurements. If the Contractor fails to correct the capacity issues within two (2) workdays liquidated damages will be assessed at $2,000 per day.

The Contractor must maintain the system capacity to complete all jobs in a scheduled cycle. The processing cycle must be completed each night to allow the system to be available each morning by 7:00 a. m. Eastern time, for inquiry and update.

Two hundred and fifty dollars ($250) each occurrence for each job eliminated from a scheduled cycle if the eliminated job is not processed in the next scheduled cycle.

30.31.19 Bank Reconciliation

30.31.19.1 Requirements

The Contractor must reconcile the statements of the claims processing bank account, on a monthly basis, in accordance with Section 30.34. Within thirty (30) calendar days of the date the Contractor receives an account Statement from the financial institution, the Contractor shall provide the Agency with a copy of the Statement accompanied by a completed reconciliation.

30.31.19.2 Liquidated Damages

The liquidated damages for failure to comply with the bank reconciliation section will be $10,000 per month for each month that the account is not in compliance.

30.31.20 HIPAA Compliance

30.31.20.1 Requirements

The Contractor must ensure it meets all federal regulations regarding standards for privacy, security, and individually identifiable health information as identified in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 as specified in Attachment B.

The Contractor must deliver, maintain and operate FMMIS/DSS in full compliance with the Health Insurance Portability and Accountability Act (HIPAA).

The Contractor is responsible for HIPAA compliance of FMMIS/DSS and the fiscal operations regardless of its status as a covered entity or business associate of the State.

30.31.20.2 Actual Damages

The actual damages for the Contractor's failure to comply with the HIPAA standards shall be any penalties that the State is assessed.

30.31.21 Perform MITA Gap Analysis

30.31.21.1 Requirements

The Contractor must complete the MITA gap analysis in a manner acceptable to the State within the time frames specified in Section 50 and in accordance with the work plan for this deliverable agreed to by the State.

30.31.21.2 Liquidated Damages

The liquidated damages will be equal to $5,000 per month for each month that the analysis is past the specified time frame or is not acceptable to the State.

30.31.22 Establish Electronic Health Records (EHR)

30.31.22.1 Requirements

The Contractor must establish an Electronic Health Record (EHR) in a manner acceptable to the State within the time frames specified in Section 50 and in accordance with the work plan for this deliverable agreed to by the State.

30.31.22.2 Liquidated Damages

The liquidated damages will be equal to $10,000 per month for each month that the EHRs have not been implemented past the specified time frame or are not acceptable to the State.

30.31.23 Correction of Deficiencies Identified by the State

30.31.23.1 Requirements

If the State identifies deficiencies in the Contractor's performance of requirements as describe in the RFP, not otherwise addressed in other liquidated or actual damages provisions, the State will require the Contractor to develop a corrective action plan within ten (10) workdays. The corrective action plan will be reviewed by the State within five (5) workdays and modified by the Contractor in five (5) workdays.

30.31.23.2 Liquidated Damages

The liquidated damages shall be equal to $500 per day for each day that the corrective action plan is late or not acceptable to the State and $1,000 per day for each day that the deficiency is not corrected, past the date specified in the corrective action plan or not acceptable to the State.

30.31.24 Deduction of Damages from Payments

30.31.24.1 Liquidated Damages

Amounts due the State as liquidated damages may be deducted by the State from any money payable to the Contractor pursuant to this contract. The State will notify the Contractor in writing of any claim for liquidated damages at least thirty (30) calendar days prior to the date the State deducts such sums from money payable to the Contractor. Such amounts as they relate to Section 30 may be deducted during the entire period that MMIS certification is lacking. Should certification subsequently be granted retroactively, the State will reimburse the Contractor for any amounts that have been withheld due to lack of certification.

30.31.24.2 Actual Damages

Amounts due the State as actual damages may be deducted by the State from any money payable to the Contractor pursuant to this contract. The State will notify the Contractor in writing on or before the date the State deducts such sums from money payable to the Contractor. Such amounts as they relate to Section 30 may be deducted from amounts currently payable to the Contractor.

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30.32 State Property

The Contractor will be responsible for the proper custody and care of any State-owned property furnished for Contractor's use in connection with the performance of this contract and the Contractor will reimburse the State for its loss or damage, normal wear and tear exempted.

The Contractor will provide the State with a list of all property under its custody and care within forty-five (45) calendar days of the beginning of the Operations Phase. The list will be updated on an annual basis and provided to the State's Contract Manager.

30.33 Prohibition of Gratuities

By submission of a proposal, the Vendor certifies that no member of or delegate of Congress, nor any elected or appointed official or employee of the State of Florida, the General Accounting Office (GAO), the Department of Health and Human Services (DHHS), Centers for Medicare Medicaid Services (CMS), or any other federal agency has, or will, benefit financially or materially from this procurement. Any contract arising from this procurement may be terminated by the State if it is determined that gratuities of any kind were either offered to, or received by, any of the aforementioned officials or employees from the Vendor, the Vendor's agent, or employee.

30.34 Banking Services

The State will contract, through a competitive process, with a bank to provide banking services. The bank will be a Qualified Public Depository pursuant to Section 280, Florida Statutes. The bank account will be a State-owned bank account with a bank operating in Leon County, with powers granted to the Contractor for banking needs under the contract. Unexpended funds in the bank account will be invested daily by the State through the Treasurer's Special Investment Account. The Contractor will be required to sign as a third party on the contract between the State and the selected bank. Bank service charges of the selected bank will be the sole responsibility of the State, unless they are a result of Contractor error.

The Contractor is responsible for ensuring that appropriate internal controls and segregation of duties, in accordance with Generally Accepted Accounting Principles (GAAP), are adhered to in all aspects of banking services.

The Contractor will be responsible for any losses resulting from inadequate internal controls or misappropriation of funds by its employees.

30.34.1 Banking Reconciliation

The Contractor shall reconcile the statements of the claims processing bank account, on a monthly basis, in accordance with the procedures approved by the Agency. Within thirty (30) calendar days of the date the Contractor receives an account statement from the financial institution, the Contractor shall provide the Agency with a copy of the statement accompanied by a completed reconciliation. The Contractor is responsible for maintaining an accounting of the balance, which reflects all activity. The book balance in this account must always be reconciled back to zero. The Contractor shall maintain canceled drafts and records related to the bank reconciliation, including check-specific details of paid items, outstanding items, stopped/voided items, and stale-dated items, and shall provide sufficient information to the Agency to verify the reconciliation of the draft account. All supporting documentation must be consistent with the ending date of the bank statement.

30.34.1.1 Blank Draft Check Stock

The Contractor shall provide the stock of blank drafts to be used in paying benefits and any hardware and software used by the Contractor for laser check printing.

30.34.1.2 Check Printing with Back-Up Capability

The Contractor will print checks within four (4) hours of the State's approval and will have emergency procedures established to print checks within four (4) hours, on another printer, should the primary check printer become non-functional.

30.34.1.3 Banking and Finance Operating Procedures

The Contractor will develop and update banking and finance desk level operating procedures that provide for all appropriate internal controls and segregation of duties. These procedures will require State review and approval. The current bank operating procedures are included in Volume 9, Book 2 of the operating procedures manual that is available in the Medicaid Procurement Library.

30.34.1.4 System Generated Check Accountability

In addition to other security measures required in the protection of blank and printed checks discussed herein, the Contractor will develop and maintain appropriate records regarding the transfer of printed checks from the banking department to the mailroom. The number of checks transferred from the banking section must match the number of checks delivered to the mailroom. The Contractor must confirm that the number of checks processed through the postage machine agrees with the number of checks delivered. Auditable records are required.

30.34.1.5 Manual Check Reconciliation and Supporting Documentation

For each manual check issued, the following documentation is required on file:

1. Correspondence requesting issuance;
2. Supervisory approval; and
3. Documentation verifying stop payment or voided check.

The Contractor will develop a database/spreadsheet reconciliation procedure to ensure duplicate manual checks are not issued as replacement for the same check/purpose, etc.

The ability to sort this database various ways will allow reviewers to determine matching data on separate entries and find errors. The Contractor is responsible and accountable for all manual checks issued. A copy of the database, both printed and electronic, will be provided to the State on a periodic basis (weekly or monthly) for audit/review.

30.34.1.6 Financial Entries to FMMIS/DSS

All activity related to the issuance of drafts, from the Medicaid Disbursement Account, including, but not limited to system generated payments, manual issuance of special payments approved by the Agency, stale-dated checks, checks returned by the Post Office as undeliverable as addressed, and returned checks, must be posted to the FMMIS/DSS, unless otherwise approved by the Agency. All stale-dated, undeliverable, stop payments and returned checks must be posted to the FMMIS/DSS within thirty (30) calendar days of the completion of the reconciliation of the current month's bank Statement.

All system-generated payments must be posted to the FMMIS/DSS in conjunction with the completion of the weekly payment cycle. (All manual issuance of special payments must be posted to the FMMIS/DSS within fourteen (14) calendar days of the issuance of the payment.)

30.34.1.7 Disbursing Account Interest

The State will establish and maintain a claims draft account for use in making payments of benefits under the Medicaid program. This account will be in the name of and for the benefit of the Agency and will be used by the Contractor only for making authorized claims payments or Medicare Part A and Part B premium payments. All funds in the account ("the float") shall be deposited in the State Treasury. The selected bank will be responsible for coordinating, on a daily basis, funding of the disbursement account with the State Treasurer. The Contractor shall withdraw, disburse, or use funds from the disbursement account solely for the purpose of paying claims and Medicare Part A and Part B premiums under the contract and shall be unequivocally and specifically prohibited from withdrawing, disbursing, or using funds from said account for any other purpose whatsoever, except upon the explicit, written instructions from the Agency.

30.35 Most Favored Customer

The Contractor agrees that if during the term thereof, the Contractor enters into any agreement with any other governmental customer, or any non-affiliated commercial customer by which it agrees to provide equivalent service at lower prices, or additional services at comparable prices, the contract will, at State option, be amended to accord equivalent advantage to the State.

30.36 Representation of Role of Fiscal Agent

In no way will the Contractor or subcontractor represent itself directly or by inference as a representative of the Florida Medicaid program except within the confines of its role as fiscal agent.

State approval must be received in all instances in which the Contractor distributes publications to the Florida Medicaid provider community.

30.37 Statistical Estimates

Current and projected statistical estimates are provided for information only. The State makes no representation whatsoever concerning the accuracy of this information. The projections are for proposal preparation purposes only and not a warranty or representation which can form the basis of the contract. Vendors are required to exercise their own diligence in evaluating the projections.

30.38 Expert Witness

The Contractor will provide expert witness services, at the level of manager or above, as needed during the term of the contract for consultation, testifying, depositions, or other needs as requested by the State for investigations, trials, or other related matters as deemed necessary by the State. The Contractor's designation of expert witnesses is subject to prior approval by the State. The State will not provide any additional reimbursement to the Contractor for provision of such services. Travel expenses for such witnesses will be reimbursed to the extent provided by Section 112.061, Florida Statutes.

30.39 Telecommunication Requirements and State Owned Equipment

The Contractor must purchase equipment over the term of this contract for office modernization and automation needs in State offices. Up to $7 million will be spent to provide equipment based upon retention and use schedules set by the State to keep State equipment working and up to date. The State will select the equipment to be provided by the Contractor. The Contractor will acquire and provide the equipment to the state at cost as a pass through expense, without additional charge for administration or profit.

The Contractor will be responsible for maintaining telecommunication circuits between the State offices and the Contractor's facility as defined in Section 40.

The Contractor will procure and deliver the equipment to State locations as identified in Appendix G. Additional equipment may be procured for State use through this contract.

30.40 Nonexpendable Property

Nonexpendable property is defined as tangible and personal property of a nonconsumable nature that has an acquisition cost of one thousand dollars ($1,000) or more per unit and an expected useful life of at least one (1) year, and hardback bound books that are not circulated to students or to the general public, the value or cost of which is two hundred fifty dollars ($250) or more. Hardback books with a value or cost of twenty-five dollars ($25) or more shall be classified as Operating Capital Outlay (OCO) expenditure only if they are circulated to students or to the general public.

All property purchased under this contract pursuant to Section 30 will be recorded and a list will be provided to the Agency. Said listing will include a description of property, model number, manufacturer's serial number, funding source, information needed to calculate the federal and/or State share, date of acquisition, unit cost, and information on the location of the property.

Title (ownership) to all property purchased for State use, pursuant to Section 30 of this contract will be vested in the State upon delivery and setup at the Agency site, and payment of the invoice.

At no time will the Contractor dispose of property purchased pursuant to Section 30 of this contract except with the permission of, and in accordance with written instructions from the State.

A formal contract amendment is required prior to the purchase of any item of non-expendable property for the State not specifically listed in the approved contract.

All other non-expendable property purchased with federal and/or State funds will become the property of the State upon termination of the contract.

30.41 Access to Libraries

Access to data dictionaries, files, file structures, programs, and documentation developed or used by the Contractor should be available to the State at all times.

30.42 Travel Expenses

The Contractor will not charge the State for any travel expense not included in the contract price without State's prior written approval. Upon obtaining the State's written approval, the Contractor will be authorized to incur travel expenses payable by the State to the extent provided by Section 112.061, Florida Statutes

30.43 Waiver

No covenant, condition, duty, obligation, or undertaking contained in or made a part of the contract may be waived except by the written agreement of the parties, and a forbearance or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply.

30.44 Disputes

The State expects that any disputes arising under the contract will be approached first through negotiations with the Agency's Contract Manager, second through negotiation with the Deputy Secretary for Medicaid, and third through negotiation with Agency Secretary or designee. Legal action should only be initiated if all of these mechanisms fail.

Venue for disputes will lie in Leon County, Florida. In any such review, the Contractor shall have the burden to prove the decision of the Agency's Contract Manager to be incorrect. Pending final determination of any dispute, the Contractor shall proceed diligently with performance of the contract and in accordance with the direction of the Agency's Contract Manager.

30.45 Indemnification

In addition to, and not in limitation of, Section I (F) of the Standard Contract, the Contractor agrees to indemnify, defend, and hold harmless the State, its officers, agents, and employees from:

1. Any claims or losses to any person or firm injured or damaged by the erroneous, negligent, or willful acts of the Contractor, its officers, directors, employees, or subcontractors in the performance of the contract;
2. Any claims or losses for service rendered by any subcontractor, person, or firm performing or supplying services in connection with the performance of the contract; and
3. Any claims or losses to any person or firm injured or damaged by the Contractor, its officers, directors, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the contract in a manner not authorized by the contract.

30.46 Inspection of Records and Work Performed

The State, the Florida Office of the Auditor General, the Department of Health and Human Services (DHHS), the General Accounting Office (GAO), or their authorized representative will, at all reasonable times, have the right to enter into Contractor's and subcontractor's premises, or such other places where duties under the contract are being performed, to inspect, monitor, or otherwise evaluate (including periodic systems testing) the work being performed. The Contractor and subcontractors must provide reasonable access to all facilities and assistance for State and federal representatives. All inspections and evaluations will be performed in such a manner as will not unduly delay work. Refusal by the Contractor or subcontractor to allow access to all documents, papers, letters or other materials subject to the provision of Chapter 119, Florida Statutes, and made or received by the Contractor in conjunction with the contract will constitute a material breach of the contract.

30.47 Accounting

The Contractor shall maintain an accounting system and employ accounting procedures and practices that conform to Generally Accepted Accounting Principles. All charges applicable to the contract shall be readily ascertainable from such records. The Contractor is required to submit annual financial reports to the Agency within thirty (30) calendar days of receipt of the report from their independent auditor.

30.48 Minority Participation Reporting

The Agency for Health Care Administration encourages the Vendor to use Minority and Certified Minority businesses as subcontractors when procuring commodities or services to meet the requirement of the contract.

The Agency requires information regarding the Vendor's use of minority owned businesses as subcontractors under this contract. This information will be used for assessment and evaluation of the Agency's Minority Business Utilization Plan. During the term of the contract, it will be necessary to provide this information monthly by the 15th of each subsequent month. A minority owned business is defined as any business enterprise owned and operated by the following ethnic groups: African American (Certified Minority Code H or

Non-Certified Minority Code N), Hispanic American (Certified Minority Code I or Non-Certified Minority O), Asian American (Certified Minority Code J or Non-Certified Minority Code P), Native American (Certified Minority Code K or Non-Certified Minority Code Q), or American Woman (Certified Minority Code M or Non-Certified Minority Code R).

The Vendor is required to complete Attachment L, Subcontractor Utilization Report Form for Commodities/Services and submit it with each invoice. Failure to provide Attachment L with an invoice shall result in a delay in processing the invoice for payment.

30.49 Force Majeure

Neither party shall be liable for loss or damage suffered as a result of any delay or failure in performance under this contract or interruption of performance resulting directly or indirectly from acts of God, civil or military authority, acts of war, riots, civil disturbances, insurrections, accidents, fire, explosions, earthquakes, floods, water, wind, lightning, strikes, labor disputes, shortages of suitable parts, materials, labor or transportation to the extent such events are beyond the reasonable control of the party claiming excuse from liability resulting there from.

Assumption of all critical operations must begin within five (5) workdays following the disaster. All critical operations must be clearly defined in the Contractor's state approved disaster recovery plan.

30.50 Audits/Monitoring

The Agency may conduct, or have conducted, performance and/or compliance reviews, reviews of specific records or other data as determined by the Agency. The Agency may conduct a review of a sample of beneficiary and other Contractor records to verify the quality of the Contractor's services. Reasonable notice shall be provided for reviews conducted at the Contractor's place of business. Reviews may include, but shall not be limited to, reviews of procedures, computer systems, accounting records, payroll audits, and internal quality control reviews. The Contractor shall work with any reviewing entity selected by the State.

30.51 Lobbying Disclosure

The Contractor shall comply with applicable federal requirements for the disclosure of information regarding lobbying activities of the Contractor, subcontractors or any authorized agent. Certification forms shall be filed by the Contractor and all subcontractors, certifying that no federal funds have been or shall be used in federal lobbying activities, and the disclosure forms shall be used by the Contractor and all subcontractors to disclose lobbying activities in connection with the Medicaid program that have been or shall be paid with non-federal funds. A copy of the Certification Regarding Lobbying is found in Attachment D. The Contractor shall comply with the provisions of Section 216.347, Florida Statutes, which prohibits the expenditure of contract funds for the purpose of lobbying the Legislature or a State agency.

30.52 Environmental Considerations

The State supports and encourages initiatives to protect and preserve our environment. The Vendor shall submit as part of its response to this RFP, the Vendor's plan to support the procurement of products and materials with recycled content and the intent of Section 287.045, Florida Statutes. The respondent shall also provide a plan for reducing and/or

handling of any hazardous waste generated by the respondent company. Reference Rule 62-730.160, Florida Administrative Code. It is a requirement of the Florida Department of Environmental Protection that a generator of hazardous waste materials that exceeds a certain threshold must have a valid and current Hazardous Waste Generator Identification Number. The identification number shall be submitted as part of the respondent's explanation of its company's hazardous waste plan and shall explain in detail its handling and disposal of waste.

30.53 Certification Regarding Debarment and Suspension

The contract to be awarded as a result of this RFP is funded in part by federal funds that exceed the $25,000 requirement; thus, the winning Contractor shall be required to sign a Certificate Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion (Attachment C) as part of the contracting process.

30.54 Patents, Royalties, Copyrights, Right to Data and Sponsorship Statement

The Contractor, without exception, shall indemnify and hold harmless the Agency and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or unattended invention, process, or article manufactured or supplied by the Contractor. The Contractor has no liability when such claim is solely and exclusively due to the combination, operation or use of any article supplied hereunder with equipment or data not supplied by the Contractor or is based solely and exclusively upon the Agency's alteration of the article. The Agency shall provide prompt written notification of a claim of copyright or patent infringement and shall afford the Contractor full opportunity to defend the action and control the defense. Further, if such a claim is made or is pending, the Contractor may, at its option and expense procure for the Agency the right to continue the use of, replace or modify the article to render it non-infringing (if none of the alternatives is reasonably available, the Agency agrees to return the article on request to the Contractor and receive reimbursement, if any, as may be determined by a court of competent jurisdiction). If the Contractor uses any design, device, or materials covered by letter, patent, or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or cost arising from the use of such design, device, or materials in any way involved in the work. Where activities supported by the contract resulting from this procurement produce original writing, sound recordings, pictorial reproductions, drawings or other graphic representation and works of any similar nature, the Agency has the right to use, duplicate and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others acting on behalf of the Agency to do so. If the materials so developed are subject to copyright, trademark, or patent, legal title and every right, interest, claim, or demand of any kind in and to any patent, trademark or copyright, or application for the same, shall vest in the State of Florida, Department of State for the exclusive use and benefit of the State. Pursuant to Section 286.021, Florida Statutes, no person, firm, corporation, including parties to this contract shall be entitled to use the copyright, patent, or trademark without the prior written consent of the Florida Department of State.

The Agency shall have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Contractor under any contract resulting from the RFP. Pursuant to Section 286.25, Florida Statutes, all non-governmental Contractors must assure that all notices, information pamphlets, press releases, advertisements, descriptions of the sponsorship of the program,

research reports, and similar public notices prepared and released by the Contractor shall include the Statement: "Sponsored by (name of Contractor) and the State of Florida, Agency for Health Care Administration." If the sponsorship reference is in written material, the words, "State of Florida, Agency for Health Care Administration" shall appear in the same size letters or type as the name of the organization.

30.55 Headings

The section and section headings and the table of contents used in this RFP are for reference and convenience only and shall not enter into the interpretation of the RFP.

30.56 Applicable Laws and Regulations

The Contractor must comply with all laws and regulations of the State of Florida, including but not limited to those listed below, and shall be liable for any costs or damages resulting from a failure to comply with laws or regulations.

Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C; Title 45 CFR, Part 74, General Grants Administration Requirements; Chapters 409, Florida Statutes; all applicable standards, orders or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 USC 1857, et seq.); Title VI of the Civil Rights Act of 1964 (42 USC 2000d) in regard to persons served; 42 CFR 431, Subpart F; Section 504 of the Rehabilitation Act of 1973, as amended; 29 USC 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance; the Age Discrimination Act of 1975, as amended; 42 USC 6101 et. seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance; the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance; the Medicare-Medicaid Fraud and Abuse Act of 1978; other federal omnibus budget reconciliation acts; Americans with Disabilities Act (42 USC 12101, et. seq.); and the Balanced Budget Act of 1997.

30.57 Symbols, Emblems or Names in Reference to Medicaid

No person or program may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words "Medicaid," or "Agency for Health Care Administration," except as required by the contract resulting from this RFP, unless prior written approval is obtained from the Agency. Specific written authorization from the Agency is required to reproduce, reprint, or distribute any Agency form, application, or publication for a fee. State and local governments are exempt from this prohibition. A disclaimer that accompanies the inappropriate use of program or Agency terms does not provide a defense. Each piece of mail or information constitutes a violation.

30.58 HIPAA Compliance

The Contractor must ensure it meets all federal regulations regarding standards for privacy, security, and individually identifiable health information as identified in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 as specified in Attachment B.

The Contractor must deliver, maintain and operate FMMIS/DSS in full compliance with the Health Insurance Portability and Accountability Act (HIPAA) including but not limited to the transaction and code set standards, privacy and security standards, and the identifier standards. The Contractor must keep FMMIS up to date with new HIPAA requirements as they are promulgated. The Contractor must send and receive all electronic transactions covered under HIPAA in the approved electronic format.

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40 TECHNICAL AND BUSINESS PROCESS REQUIREMENTS

In broad terms, this section of the RFP describes what must be done during the Operations Phase of the contract. In the past, this section would have been based on the technical requirements of each MMIS Subsystem as defined in the State Medicaid Manual (SMM). As a step toward implementation of the Medicaid Information Technology Architecture (MITA), this section is organized based on business domains and functional requirements. In each area, the State seeks to advance the MITA maturity level of the MMIS, to replace manual or inefficient processes with more efficient ones.

The State seeks a solution in each area with the greatest degree of re-usability, flexibility, and economy. The State will work with the Contractor and State business partners toward interoperability with other computer systems. The State requires HIPAA compliance throughout the system, including new HIPAA requirements as they are issued.

The State encourages use of Commercial-Off-The-Shelf (COTS) products when practical to meet the needs of the business function, and encourages use of best-in-class subcontracts when other vendors may offer superior experience and solutions.

The Vendor must respond to all the requirements in Section 40, explaining their technical approach, identifying tools to be used, describing staffing commitments and explaining in detail how they will meet all requirements. Specifically the Vendor must:

- Respond in detail to every item in Section 40.1;
- Acknowledge all information contained in the Overview, State Objectives, Interfaces, Inputs, Outputs and State Responsibilities paragraphs of Sections 40.2 through 40.5;
- Respond in detail to every item under Contractor Responsibilities in Sections 40.2 through 40.5; and
- Complete Appendix O, indicating the level of complexity or modifications necessary to meet the requirements indicated in the matrix.

40.1 General Requirements

40.1.1 Overview of New MITA Concept and RFP Design

Medicaid Information Technology Architecture (MITA) is an initiative of the Centers for Medicare and Medicaid Services (CMS) to modernize the architecture, organization and processes involved in Medicaid Management Information Systems (MMIS). When fully defined, MITA is expected to become the set of standards that are required for systems that are developed with enhanced Federal Financial Participation (FFP). Under MITA, certification of the MMIS will focus less on the subsystems defined in the State Medicaid Manual (SMM), and more on modern analysis of Medicaid business needs and functions, more current information technology architecture, modern methods of system development, and increased interoperability of systems.

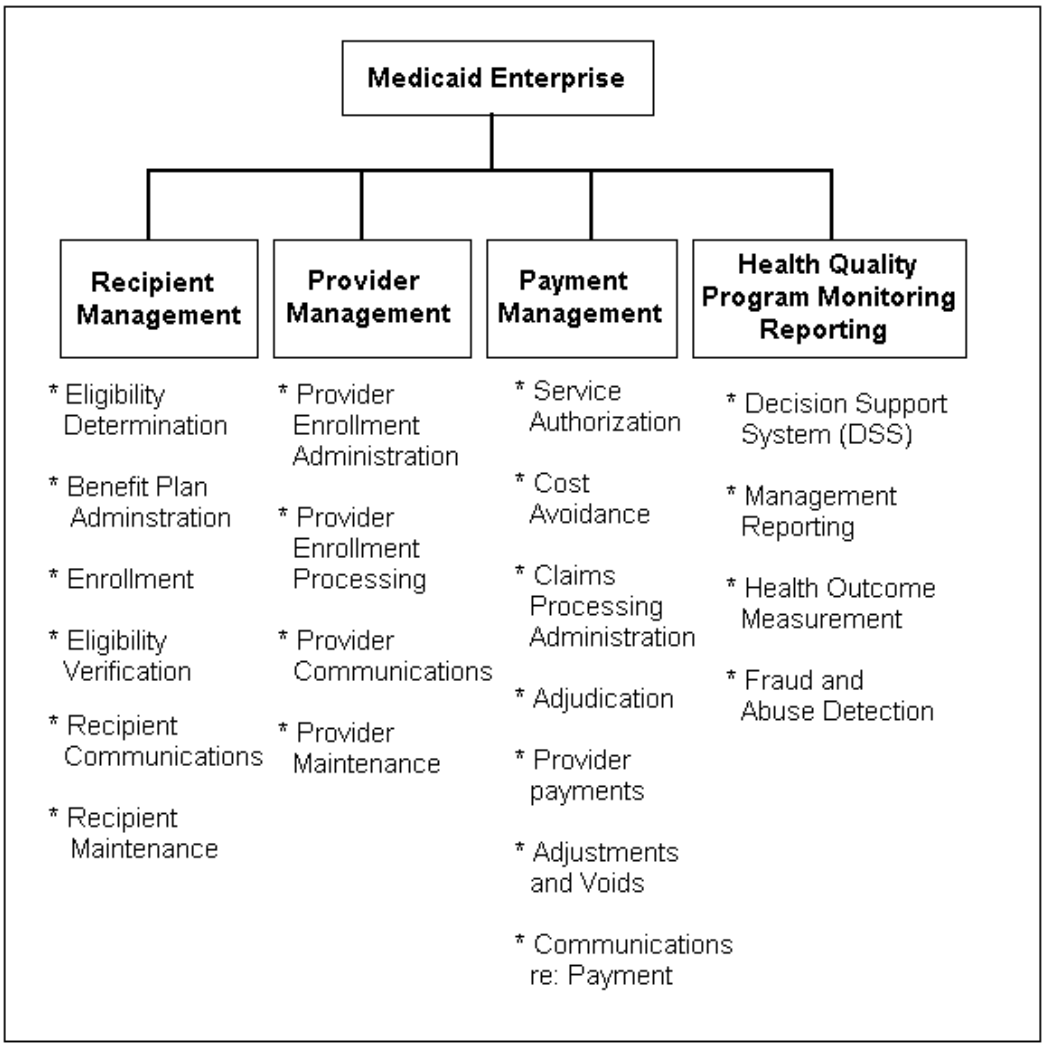
However, MITA has not been finalized by CMS, and the Contractor must design, develop and install an MMIS that will pass certification by CMS and qualify for the maximum available Federal Financial Participation (FFP). This may require proof of functional equivalence for all subsystems defined in the SMM.

Florida supports the MITA initiative by CMS to broaden the application of information technology and system interoperability for Medicaid systems, but has not chosen to be a MITA early adopter. Vendors are encouraged to consider MITA principles, standards

and architecture configurations in their technical approach to FMMIS/DSS. The MITA initiative suggests the use of tools that cross business functions. Specific MITA elements that may be of use in several FMMIS/DSS business functions include:

- Rules Engines;
- Workflow Engines;
- Web portals;
- Call Center Management systems;
- Translators;
- Automated letter generators;
- Desktop publishing systems;
- Computer Based Training (CBT) systems; and
- Automated, Web-based survey tools.

Following the MITA principles, the technical and business process requirements have been organized along the lines of the Medicaid business areas that are supported by FMMIS/DSS and/or Contractor fiscal agent and Agency business processes. The diagram below illustrates the structure of business areas and sub areas as described in this section.



40.1.2 Overview of General System and Business Requirements

The following requirements in this section (Section 40.1 and subsections) provide the general system and business requirements that the Contractor must meet. These requirements may be superseded by more stringent technical and business requirements for the specific business functions.

Most of these business requirements are being supported by the current FMMIS. Vendors must further evaluate current requirements and functionality by reviewing the FMMIS system documentation and DSS system documentation in the Medicaid Procurement Library to ascertain the minimum degree of automation required to be supported in FMMIS/DSS if not specifically addressed in Section 40.

The Contractor must also consider and plan to address the impact of all Customer Service requests (CSRs) that will be requested and performed within the current FMMIS and DSS between the time this RFP is issued and the time the new FMISS/DSS implementation is complete.

40.1.2.1 Performance Standards

The Contractor will be measured in all of the business function areas for quality system and operational performance based upon criteria developed by the State. The State believes that this will:

- Improve the quality of Contractor performance;
- Provide documented performance levels in all critical areas of the system;
- Improve the management of the fiscal agent contract; and
- Improve the State and federal government return on investment for administration of the Florida Medicaid program.

The State will identify areas of Contractor performance where quality is critical to the mission of the Florida Medicaid program. During contract implementation, the State will reach agreement with the Contractor concerning the levels of quality that are desirable, acceptable and substandard. The Contractor will develop and/or install the Performance Reporting System (See Section, 40.5.3 Management Reporting) as a means to measure quality levels on a monthly basis. The State will establish a range for Contractor performance for high quality, acceptable quality, and performance that will require corrective action on the part of the Contractor. (See Section 30 for a complete discussion of the Performance Reporting System.)

During the course of the contract, performance standards will be measured by the State, using the Performance Reporting System. State contract management will actively participate with the Contractor in using the Performance Reporting System and will approve the results recorded.

40.1.3 Data Processing Standards

The Contractor is required to implement and maintain FMMIS/DSS with strict adherence to published, industry recognized data processing standards.

40.1.3.1 FMMIS System Architecture Requirements

The Contractor must design, develop, thoroughly test, and implement a FMMIS that takes advantage of new technologies. The business functional needs of the Florida

Medicaid program will drive the procurement of this new system rather than the traditional subsystem-based architecture of the past.

All hardware and storage space required to operate FMMIS will be included in the contract, purchased and maintained by the Contractor. At termination of the contract the hardware becomes the property of the State. The Contractor must pay all packaging, shipping and shipping warranty costs to transport hardware to a location in Tallahassee designated by the State.

The Contractor should propose their best solution(s) for providing the optimal system architecture possible to support the RFP business requirements, and that must:

1. Utilize rules-based and modular components;
2. Provide ancillary functions necessary for the operation of a Medicaid fiscal agent, including banking, enrollment brokering, Fraud and Abuse Detection, actuarial rate setting, program quality monitoring and review, third party liability/coordination of benefits, estate recovery, Managed Care Organization (MCO) support, Pharmacy Benefits Management (PBM), Primary Care Case Management (PCCM), various alternative service networks, and other such services as the Contractor or State may determine necessary to manage the Medicaid program;
3. Provide FMMIS/DSS access for the State that always includes Area Offices, designated contractors at State facilities, designated contractors at independent locations, and Medicaid headquarters staff designated by the State;
4. Provide online browser-based Web capabilities for all authorized users, including providers and recipients;
5. Employ the best available tools and support open architecture software that is flexible and cost effective to modify and maintain;
6. Contain the functionality to successfully automate as many current manual or inefficient processes as possible;
7. Provide the ability to seamlessly integrate with installed COTS product components and maintain the most current updated version of the product(s);
8. Provide version update(s) at no additional cost to the State including expanding system capacity;
9. Ensure full HIPAA compliance;
10. Provide functionality to interface with multiple entities outside of the FMMIS for exchange of information; and
11. Offer a design engineered with the MITA initiative in mind.

40.1.3.2 DSS System Architecture Requirements

The replacement Decision Support System (DSS) must take advantage of the advancements in system architecture and Web technologies to provide an economical and flexible data storage system. The DSS must integrate seamlessly with the FMMIS and take advantage of system interoperability and interface technologies. The Contractor must take into consideration the needs of the less

technical user as well as the more sophisticated user and provide a solution to meet the informational needs of the State at all levels.

The DSS shall function as a data storage repository for recipient, provider, claim, reference and encounter data, and data sets from external sources that may be designated by the State. The Contractor must provide a DSS with sufficient space and planning for efficient operations and growth throughout the life of the contract. All hardware and storage space required to house the data must be included in the contract, purchased and maintained by the Contractor. At termination of the contract the hardware becomes the property of the State. The Contractor must pay all packaging, shipping and shipping warranty costs to transport hardware to a location in Tallahassee designated by the State. In addition the DSS must:

1. Maintain data sets approved by the State for all tables, including provider, recipient, claims, encounters, and reference:
    a. Implement a data model that is flexible and allows for the addition of new data elements with minimal effort;
    b. Include all necessary data elements to perform all business functions described in this RFP;
    c. Maintain the most recent seven (7) years of paid and denied claims and encounter data;
    d. Maintain all purged prior years' claim and encounter data in a separate file or files for ad-hoc reporting. Each year must be maintained on a separate file to allow the query of the data as it was at the end of the reporting year;
    e. Maintain a minimum of seven (7) years of recipient historical eligibility and claim information in order to track changes in a recipient's health status over time; and
    f. Maintain risk-adjusted data based on the most recent two years of eligibility and paid claims.
2. Integrate robust user-friendly query, analysis, and reporting tools and functionality including:
    a. Provide sufficient processing/storage for the creation of reports and statistics by State staff, a minimum of 2.5 Terabytes at the beginning of the contract and increasing each year if necessary based on utilization statistics;
    b. Support a variety of output capabilities including CD, DVD, tape, FTP and other methods as determined by the State;
    c. Provide the functionality to allow authorized State users the ability to link between Contractor tables and user-defined tables as necessary;
    d. Provide the ability for certain State users to retrieve data from any DSS table via ODBC and other available database interfaces;
    e. Provide Web-based access to DSS functionality; and
    f. Provide reliability, stability, and recoverability.
3. Support all users authorized by the State:
    a. Support at least 600 named users of the DSS;

b. Support at least 200 average users each week; and

c. Support users at Area Offices, headquarters, other State agencies, and other locations authorized by the State.

40.1.3.3 Software/Hardware Configuration

The State has based the requirements for the future FMMIS/DSS on the current, as well as anticipated, needs of the Florida Medicaid Program. While any hardware platform may be proposed that meets these requirements, the State requires software/hardware configuration that can accommodate future changes in the Medicaid program, changes in standards and transactions, and increased transaction volumes. The Contractor must:

1. Provide a software and hardware solution that is upgradeable and expandable:
   a. Perform regular maintenance to ensure optimum performance;
   b. Perform resource capacity utilization and capacity planning; and
   c. Implement needed expansions at the Contractor's own expense before 90% of maximum capacity is reached.
2. Ensure all hardware, software or communications components installed for use by State staff are compatible with the State currently supported versions of the Microsoft Operating System, Microsoft Office Suite and Internet Explorer:
   a. Version upgrades must be applied in a controlled manner to prevent disruption to users; and
   b. Test and implement operating system patches and upgrades according to State policies.
3. Support current technologies for data interchange (e.g. XML).

40.1.3.4 FMMIS/DSS Transaction Processing Requirements

1. Provide Web-based FMMIS/DSS access that requires no desktop software except the State standard version of Windows™ Internet Explorer;
2. Provide system screens that are easy to read, user friendly and display all data elements necessary for a user to perform his/her job function;
3. Design all screens with input from State users and subject to State approval during the Design and Development Phase of the contract;
4. Provide both FMMIS and DSS availability twenty-four (24) hours per day and seven (7) days per week, other than for scheduled maintenance;
5. Provider Pharmacy POS system availability twenty-four (24) hours per day and seven (7) days per week, other than for scheduled maintenance;
6. Ensure that document images are quickly available to users at their desktop;
7. Return standard screen inquiries within three (3) seconds;
8. Provide online documentation and instructions for system use;
9. Provide a single point of sign-on for all FMMIS/DSS activities;
10. Provide online functionality including:

a. Online, context-sensitive help;

b. Hovering;

c. Drop down lists and menus;

d. Point and click; and

e. Cut and paste.

11. Provide search capability based on wild cards or any combination of fields. For Web portals, provide site-wide search capabilities for all documents within the Web portal;

12. Provide field level and role-based security that allows only authorized users to see the information necessary to perform their job efficiently. Role based security must also be available that allows a level of security to be applied to a specific job category;

13. Develop searchable screens that are applicable to specific business areas for example: recipient, provider, benefits, reference data, claim types, Service Authorization, change management, TPL, and financial;

14. Provide an audit trail for each transaction on the screen identifying who made the change, what change was made, date/time the change was made, why the change was made and provide a record of the data prior to the time the change was made;

15. Provide the functionality to carry and display all data elements contained on each data record; and

16. Provide a "Screen Print" function button that will create a user friendly formatted print of screens applicable to their specific business area (for example, recipient, provider, benefits, reference data, claim types, Service Authorization, change management, TPL and financial). The layout for these formatted prints will be determined during the Design and Development Phase subject to approval by the State.

40.1.3.5 DSS Information Processing Requirements

1. DSS query applications must be Web-based, requiring no desktop software except the State-standard version of Windows™ Internet Explorer. DSS statistical, GIS, reporting and analysis functions may require COTS software to be supplied by the Contractor;

2. Allow authorized internal and external users to download and sort report information on user PCs in a variety of formats such as Excel, DBF, TXT, CSV, HTML, character delimited or flat files;

3. Provide both column- and row-level security access for enhanced HIPAA security on a need-to-know basis;

4. Queries against single, indexed files must be returned within 10 seconds. Queries returning more than 100 rows may be paged for immediate query, with the first 100 rows being returned within 10 seconds; and

5. Queries and reports relating two or more files or on fields not indexed must be returned in a time frame acceptable to the State, comparable to the performance of the State's existing system.

40.1.3.6 Programming Language Requirements

All Graphical User Interface (GUI) front-end, database, middleware, and communications software must be written in languages approved by the State and compatible with the State computing environment. The State will approve industry-standard languages appropriate to the task that operate without additional add-on licenses. Alternate languages may be proposed with the understanding that they must be approved by the State.

40.1.3.7 System Modification and Change Control Requirements

To assist State staff in establishing reasonable completion dates and setting priorities for modifications, the Contractor must maintain a Change Management System. This system will allow State and Contractor management staff to review current priorities and timeliness, change priorities by adding new tasks and target dates, and then immediately see the impact of these new priorities on pre-existing priorities and their target dates. This reporting will allow review of system programmer/analyst slack time, status of phase completion, and rapid readjustment of target dates based on system staff being reassigned to new projects and priorities. It is imperative that all modifications to FMMIS/DSS be performed in a structured, controlled manner. To this end, the State will:

- Initiate, approve or deny all Customer Service Requests (CSRs);
- Monitor the development and implementation of enhancements or modifications to FMMIS/DSS;
- Negotiate all amendments to the contract; and
- Represent the State at CSR meetings to review project progress, system integrity, and the effects of changes on the FMMIS.

The Contractor must provide a Change Management System to support all system modification and change control activities. Additionally, the Contractor must implement and use proven promotion and version control procedures for the implementation of modified system modules and files. The following requirements must be met:

1. Provide the State with online access to a Change Management System:
    a. Allow online entry of new Customer Service Requests (CSRs);
    b. Image and include all attachments pertinent to each CSR;
    c. Provide online reporting and status inquiry for any CSR, all CSRs or all CSRs in a category;
    d. Provide automatic notification to affected parties when CSR status changes;
    e. Maintain and provide access to all changes made by the State or the Contractor to each CSR, identifying the change made, the person making the changes, and the date and time of the change.
    f. Show status, report coding changes, attach test results, and record all notes from State and Contractor staff related to each CSR; and
    g. Provide other data related to each CSR as requested by the State during the Design and Development Phase.

2. Provide an on-demand CSR status priority report and an on-demand report showing the current status of all CSRs. Information for these reports must be updated at least weekly;
3. Initiate CSRs when problems are found by the Contractor;
4. Produce reports with varying content, format, sort, and selection criteria;
5. Produce reports that are downloadable to other formats, such as Excel;
6. Information to be captured shall include, at a minimum, the following:
    a. Customer Service Request number;
    b. Priority number;
    c. Modification description;
    d. Modification related notes or comments;
    e. Request date;
    f. Requester;
    g. Modification start date;
    h. Assigned resource(s);
    i. Estimated completion date;
    j. Estimated hours;
    k. Hours worked to date;
    l. Documentation impact and status;
    m. Testing status; and
    n. State Modification approval.
7. Maintain documented, proven code promotion procedures for promoting changes from the initiation of unit testing through the final implementation to production;
8. Maintain documented version control procedures that include the performance of regression tests whenever a code change or new software version is installed, including maintaining an established baseline of test cases to be executed before and after each update to identify differences;
9. Ensure the Contractor provides the specified number of staff required to complete a CSR within the specified timeframe;
10. Ensure that all CSR requests are responded to within five (5) workdays or within twenty-four (24) hours for an emergency CSR;
11. Ensure an approved CSR has been started on within five (5) workdays of approval; and
12. Randomly survey the submitters of CSRs to verify that the user was satisfied with the timeliness, communication, accuracy, and result of the CSR process 90% of the time.

40.1.3.8 Application Development and Testing Requirements

The State requires isolated test environments designed to ensure computer applications are developed as specified. Separate test regions (e.g. unit, system, integration, and user acceptance, etc.) along with test data and appropriate copies of the logic modules that make up the system must be established and maintained during the Operations Phase. Version control procedures and update schedules must be used to facilitate tests, track discrepancies and facilitate regression test analysis. The Contractor must provide the State with isolated test environments, described below, to conduct independent integrated testing.

User Acceptance Test Environment (UAT) — an environment that allows users to perform system functions to ensure the system meets the requirements and expectations of the user community. Users perform scenarios that mimic production work to ensure the system acts and performs as expected. Scenarios are defined to ensure that requirements are thoroughly tested by the user. User Acceptance Testing will include scenarios that test all components and interfaces.

Impact Analysis Environment — an environment that allows business users to test actual or potential changes to business rules and procedures. This environment will allow the business user to perform “what if” testing to assess the impact of a proposed business rules change resulting from policy/legislation changes.

Training Environment — an environment that allows the State to provide hands on training for users. This environment will allow the State to maintain unique data for use in training and to conduct training without interference with other test and production environments.

1. Provide separate development and testing environments that:
    a. Mirror all programs in production including reports and financial records;
    b. Include a complete online FMMIS/DSS test system, including a test version of all batch and online programs and files to be used for testing releases and non-release changes;
    c. Provide a library of test cases that may be selected and modified by the user for testing. Library must have search capability that is cross referenced to the logic/edit that test case is designed to test;
    d. Provide the ability to execute impact analysis testing of any proposed change;
    e. Provide the ability to create “what-if” scenarios and compare results between scenarios in a test environment;
    f. Provide the ability to estimate what changes would need to take place in benefit plans (service limitations, aggregate dollar ceilings, provider payment rates, or other combinations) to control State overall Medicaid expenditures to a specified growth rate from one State fiscal year to the next;
    g. Provide the ability to maintain regression test cases to support regression testing;
    h. Provide the ability to save and reuse test cases without the need to re-enter the data;
    i. Are available to all appropriate Contractor and State-designated staff;

j. Provide for testing of all Customer Service Requests (CSRs) before implementation; and

k. Allow users to create and edit provider, recipient, and health plan records for testing.

2. The Contractor must create and execute a State-approved test plan for each CSR before the CSR is implemented;

3. Conduct repeatable testing in accordance with written processes and procedures approved by the State. The processes and procedures will not be changed without prior approval by the State. Test plans will be created for major system changes or as otherwise requested by the State and should include the following steps (Test plan requirements are addressed in detail in Section 50.1):

   a. Unit Testing (or Bench Testing);

   b. Structured Data Tests;

   c. Volume Testing;

   d. Operations Readiness Testing;

   e. Parallel Testing;

   f. Beta Testing;

   g. Regression Testing;

   h. User Acceptance Testing; and

   i. Retesting.

4. Documentation of test results on all system changes will be given to the State for review; and

5. Implementation will only begin after approval from the State.

40.1.3.9 Data Imaging and Data Entry Requirements

The Contractor must provide a data imaging and retrieval process, which provides, at a minimum, the following functionality:

1. Allows access to FMMIS/DSS and document images with a single logon;

2. Provides the ability to capture and store a computer image of all Medicaid related documents, both incoming and outgoing, as designated by the State including claims, claim attachments, data entry forms, medical records, correspondence, incoming and outgoing fax documents and system generated reports:

   a. An image control number (ICN) must be assigned to each document;

   b. Images will be retrieved through LAN servers available to both the Contractor and State staff;

   c. All historic images from the existing FMMIS and new images from FMMIS/DSS must be available to both the Contractor and State staff from the start of the contract awarded as a result of this RFP; and

   d. Imaging may include red-filtering or other techniques to improve readability.

3. The image must be stored in a manner to allow immediate retrieval until the imaged document has been entered, edited, and added to FMMIS/DSS historical files:
    a. Images must be stored by ICN and accessible by online search via hypertext link from all screens that reference the image; and
    b. State and Contractor staff must be able to retrieve any image stored in the most recent twelve months within ten (10) seconds. Each subsequent page of the same document (or a claim and its attachments) must be displayed in one (1) second or less.
4. After the claim, or other imaged document, has been entered into the FMMIS, the image must be transferred to optical disc jukeboxes (or similar technology) for continued retrieval. All images stored more than 12 months must be retrievable within one (1) workday of the request;
5. All imaged documents must be retained for a period of seven (7) years. Once the image has been verified, the image becomes the official copy of the document. Paper source documents may be archived or destroyed after the image has been verified, following a schedule and procedures to be approved by the State. In most cases, image source documents may be archived after thirty (30) calendar days and destroyed after ninety (90) calendar days;
6. The State must be able to print hard copies of the imaged documents as needed;
7. Images displayed on workstations must be full images, with the same look as the original piece of paper that was scanned;
8. At the termination of the contract, the Contractor will turn over to the State, or its designated agent, all optical disks or other storage media used to fulfill the imaging, retrieval and storage requirements;
9. The proposed imaging system configuration must address the following key issues:
    a. Security and Confidentiality – all data on magnetic and optical disc must be governed by the same security and confidentiality rules as the rest of FMMIS/DSS data;
    b. Back up – all imaged data must be backed up and archived. The backup and achieve rules must be the same as they are for the rest of FMMIS/DSS data; and
    c. Auditing – the data on magnetic discs must be audited, at a minimum, every week to ensure that the transfer from magnetic to optical disc is without error. Any un-transferred or erroneous records on magnetic disc must be fully accounted for.
10. The Contractor must provide the capabilities to print images to a network printer and to provide the capability to fax the image; and
11. All images must be available to the State within two (2) workdays of creation.

40.1.3.10 Data Quality Control

The Contractor must apply professional principles of data management and data quality control. The Contractor must describe the methods and tools for maintaining data quality control:

1. All tables must be properly normalized or de-normalized for efficient operation;
2. Relations among tables within databases must be properly set and controlled;
3. Database integrity tools must be used to enforce field and relationship requirements;
4. Controls must be in place to prevent duplicate or orphan records;
5. Transactions must provide for error recovery; if the entire transaction does not process completely, the entire transaction is rolled back;
6. Communications routines must use checksums or other tools to assure accuracy of the file before it is processed; and
7. HIPAA transaction processing must be tested and validated according to guidelines developed by the Strategic National Implementation Process:
    a. Test for integrity and syntax;
    b. Test for adherence to national implementation guides;
    c. Test for balancing;
    d. Test for situational elements in the State implementation guide;
    e. Test for code set conformance; and
    f. Test for each specialty, line of business or provider class.

40.1.3.11 Security and Confidentiality Requirements

The Contractor must ensure that FMMIS/DSS conforms to the relevant principles of the following Federal Information Processing Standards (FIPS) Publications, government documents and any updated publications:

1. Automatic Data Processing Physical Security and Risk Management (FIPS PUB 31);
2. Computer Security Guidelines for Implementing the Privacy Act of 1974 (FIPS BUS 41);
3. HIPAA Privacy and Security Rules; and
4. AHCA IT Security Manual.

The Contractor must implement a security system that can limit certain users to inquiry only access. The State will approve State personnel authorized to access FMMIS/DSS in any mode. Security codes must be changed according to State policy.

The Contractor must ensure that all systems, procedures, practices and facilities are fully secure and protected.

It is the intent of the State that all of the activity covered by this RFP be fully secured and protected by satisfactory security arrangements. The State and the Contractor will establish a joint security management team to accomplish these objectives.

The Contractor must treat all information obtained through its performance under the contract as confidential information and will not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securing of its rights, or as otherwise provided herein. State or federal officials, or representatives of these parties as authorized by federal law or regulations, will have access to all confidential information in accordance with the requirements of State and federal laws and regulations. The State will have absolute authority to determine if and when any other party is allowed to access FMMIS/DSS confidential information.

Data Security

1. Provide both column- and row-level security access for enhanced HIPAA security on a need-to-know basis;
2. Provide a secure climate controlled area for storage of large volumes of paper files (including take over of currently archived documents), such as medical records, in close proximity to the Contractor's office building location;
3. Provide secure transmission of batch and all other claims;
4. Provide secure email for all Contractor staff, including mail services to determine when email must be encrypted, and executing that encryption;
5. Maintain a secure link between the AHCA Web site and the Contractor's Web site;
6. Provide password protection and password renewal capability. FMMIS/DSS may not allow generic or shared passwords, except as specifically authorized by the State;
7. Provide authorized providers with the capability to access and view a claim(s) as they submitted it, inquire on recipient eligibility, and obtain Service Authorization status;
8. Future enhancements could give recipients their own secure "portal" providing them with online and real-time ability to view their personal data, request changes, request protected health information (PHI), and view claims filed on their behalf from providers;
9. The Contractor must provide:
    a. Complete control and accounting of all data received, stored, used or transmitted by the Contractor for Florida Medicaid to assure administrative, physical, and technical security of the data;
    b. A system security software product which is fully functional and operational in the EDP environment, including that portion controlled by the Contractor and that portion controlled by the State. In managing this feature the Contractor must log and report to the full security management team all unauthorized attempts to access FMMIS/DSS; establish a limit of unsuccessful attempts to access FMMIS/DSS after which the user will be disconnected; disconnect any user for whom a limit has been reached; and, provide automatic logoff of a user if a key is not depressed within the time established by the State;

c. Dial up access protection to permit FMMIS/DSS access only from authorized locations. In managing this control feature, the Contractor must provide automatic redialing by the central EDP facility as part of the connect/sign on process to the previously authorized telephone number stored in the system; log and report to the security management team all unauthorized attempts to access FMMIS/DSS; and, establish a limit of access attempts after which a dial-up line will be disconnected;

d. Complete confidentiality of all passwords and IDs used by the Contractor and State employees. No individuals will be allowed to share password IDs with each other;

e. Ensure the security of all State documents and data. The Contractor must provide complete segregation of the State data and files from the data and files of other Contractor customers;

f. Provide access to all new State and Contractor staff within two (2) workdays of employment, following all required security checks and protocols;

g. Terminate access for all terminated Contractor employees by the end of their last business day, and within one (1) workday of notification by the State for State-designated staff;

h. At the direction of the State, set up a system to automatically terminate all users who have not accessed the system in a specified number of days; and

i. Conduct monthly physical security audit of selected requirements to ensure compliance with HIPAA.

10. The Contractor must establish security access to FMMIS/DSS for its own users, for Agency staff and for all other State-authorized staff:

    a. Use convenient, secure and Web-based methods to receive requests for authorization to access FMMIS/DSS and for State staff to approve and grant access;

    b. Load lists of authorized users from data sources supplied by the State;

    c. Design, distribute, gather, process and file paper Security Authorization Forms to ensure access is granted only to State-authorized staff; and

    d. Process Security Authorization Forms for FMMIS/DSS users in the Agency, the Florida Department of Children and Families, the Florida Department of Health, the Florida Attorney General's office and all other agencies and contractors designated by the State.

11. The Contractor must employ traffic and network monitoring software and tools on a regular basis to identify obstacles to optimum performance:

    a. Identify email and Internet spam and scams and restrict or track user access to appropriate Web sites;

    b. Detect and prevent hacking, intrusion and other unauthorized use of Contractor resources;

    c. Prevent adware or spyware from deteriorating system performance;

    d. Update virus blocking software daily and aggressively monitor for and protect against viruses;

e. Monitor bandwidth usage and identify bottlenecks that impede performance;

f. Provide methods to flag recipient data to exclude PHI from data exchanges as approved by the State, and to comply with recipient rights under the HIPAA privacy law for:

(1) Requests for restriction of the uses and disclosures on PHI (45 CFR 164.522(a));

(2) Requests for confidential communications (45 CFR 164.522(b)); and

(3) Requests for amendment of PHI (45 CFR 164.526).

Physical Security and Access to Data Processing Facilities

The Contractor's Computer Resource Center (CRC) shall be housed in a secure area, protected by a defined security perimeter, with appropriate security barriers and entry controls to include, but not limited to:

1. Physical access to the CRC will be controlled;
2. Access by visitors to the CRC shall be recorded and supervised; and
3. Access rights to CRC will be regularly reviewed and updated.

The Contractor will insure that communication switches and network components outside the central computer room shall receive the level of physical protection necessary to prevent unauthorized access.

1. The Contractor will designate one or more persons responsible for the security of each facility;
2. The Contractor, or subcontractor with administrative control (i.e. primary physical access) over wiring closets, communications and service rooms, will ensure that they are properly secure to protect Information Resources and to not allow unauthorized access to sensitive information.

The Contractor will ensure that proper controls over temperature, humidity, air movement, cleanliness, and power shall be maintained to avoid computer downtime and malfunctions. Designated employees shall be trained to monitor environmental control procedures, equipment and response procedures in case of emergencies or equipment problems.

1. Environmental control requirements will be considered during the Design and Development Phase in acquisition of new facilities and systems; and
2. Adequate and appropriate environmental operating conditions will be ensured for Information Resources, and maintenance procedures implemented per the Contractor’s specifications.

Equipment shall be reasonably protected from power failures and other electrical anomalies. A suitable electrical supply shall be provided which:

1. Includes an uninterruptible power supply (UPS) for equipment supporting critical business operation to support orderly shut down or continuous running. Equipment shall be regularly checked to ensure it has adequate capacity and tested in accordance with the manufacturer's recommendations;
2. Back-up generators in the event of power outage;

3. May include multiple feeds to avoid a single point of failure in the power supply; and
4. May include surge protection devices.

Power and telecommunications cabling carrying information or supporting information services shall be protected from interception or damage. The Contractor will document what existing power and/or cabling is covered by this standard and communicate that to AHCA management for appropriate protective action.

Regardless of ownership, the use of any equipment outside the Contractor's premises for information processing of State business requires approval of AHCA management. The security provided should be equivalent to that for on-site equipment used for the same purpose, taking into account the risks of working outside the Contractor's premises. Information processing equipment may include, but is not limited to, all forms of personal computers, personal digital assistants, mobile telephones, or similar devices, which are held for home working or are being transported away from the normal work location.

Physical Security for Staff

The Contractor must provide:

1. A safe and secure work site with electronic entry monitored by security personnel, outside security camera and adequate lighting;
2. Backup generators in the event of power outage;
3. A smoke free environment following the State's no-smoking guidelines;
4. A secure dedicated space for State staff at the Contractor's worksite (see Section 50.3.2.1, Location of Operations Facilities, for details of State space); and
5. A secure banking area with additional security for storage and processing of checks and other highly sensitive documents.

Disaster Recovery and Back-up

In the event of a natural or man-made disaster all data/files in FMMIS/DSS must be protected in an off-site location. In addition, the Contractor must provide an alternate business area site in the event the primary business site becomes unsafe or inoperable. Back-up of all system (FMMIS/DSS) files must occur on a daily basis to preserve the data integrity of both historical and current data. The Contractor must maintain a State approved disaster recovery and back-up plan at all times. It is the sole responsibility of the Contractor to maintain adequate back-up to ensure continued automated and manual processing. This plan must be available to State auditors at all times. At a minimum, the Contractor's disaster recovery plan must provide for the following:

1. Check point/restart capabilities;
2. Retention and storage of back-up files and software;
3. Hardware back-up for the main processor;
4. Contractor–provided telecommunications equipment;
5. Network back-up for telecommunications;

6. Assumption of all critical operations within five (5) workdays following the disaster. All critical operations must be clearly defined in the Contractor's State approved disaster recovery plan;
7. Back-up procedures and support to accommodate the loss of online communications between the Contractor's processing site and the State. These procedures must specify the alternate location for the State to utilize FMMIS/DSS online system in the event FMMIS/DSS is down in excess of two (2) workdays;
8. A detailed file back-up plan and procedure including the off-site storage of all critical transaction and master files. The plan must also include a schedule for their generation and rotation to the off-site facility;
9. The maintenance of current system documentation, user documentation, and all program libraries;
10. The Contractor must perform an annual review of the disaster recovery back-up site, procedures for all off-site storage, and validation of security procedures. A report of the back-up site review must be submitted within sixty (60) calendar days of the review. The State reserves the right to inspect the disaster recovery back-up site and procedures at any time with twenty-four hour notification;
11. Develop and maintain a State approved disaster recovery plan that contains detailed procedures that will be followed in the event of a disaster;
12. Maintain the disaster recovery plan online and in hard copy;
13. Update the disaster recovery plan on a schedule defined by the State;
14. Maintain an alternate operations site for use during immediate disaster recovery for FMMIS/DSS;
15. Provide space for up to ten (10) State staff in the Contractor's disaster recovery site for State employees; and
16. Back-up all FMMIS/DSS files daily on a media and in a format approved by the State. FMMIS/DSS back up files must be stored in a secure off site location

40.1.3.12 Documentation

FMMIS/DSS Systems Documentation

1. The Contractor must implement and maintain FMMIS/DSS documentation. The Contractor must provide six (6) copies to Medicaid Contract Management within sixty (60) calendar days prior to the Operations Phase. In addition to the hard copies, all FMMIS/DSS documentation must be maintained online, with access by State authorized personnel. For changes during operations, six (6) updated copies of the documentation must be prepared to reflect any modifications, corrections, or enhancements to FMMIS/DSS and must be delivered to Medicaid Contract Management within fifteen (15) calendar days of the State's approval of implementation of the change. Any documentation not approved by the State must be corrected and resubmitted by the Contractor within fifteen (15) calendar days of the transmittal date. The electronic version of the approved system documentation must be posted to the Web site within three (3) workdays of the State's approval. The Contractor is responsible for providing the copies requested by CMS;
2. The following standards will apply to FMMIS/DSS system documentation:

a. The documentation must be prepared in a format that facilitates updating;

b. System and module narratives must be written so that they are understandable by persons not trained in data processing;

c. The documentation must contain an overview of FMMIS/DSS, including general system narrative, general system flow, and a description of the operating environment. The nomenclature used in the overview shall correspond to the nomenclature used in the module documentation. All modules must be referenced, and documentation must be consistent across all modules;

d. Module level documentation, for each module, must contain:

(1) Module name and numeric identification;

(2) Module narrative;

(3) Module flow, identifying each program, input, output, and file;

(4) Job streams within each module, identifying programs, inputs and outputs, control, job stream flow, operating procedures, and error and recovery procedures;

(5) Name and description of input documents, example of documents, and description of fields or data elements on the document;

(6) Listing of the edits and audits applied to each input item and the corresponding error messages;

(7) Narrative and process specifications for each program;

(8) Screen layouts, report layouts, and other output definitions, including examples and content definitions;

(9) Listing and description of all control reports;

(10) File descriptions, and record layouts, with reference to data element numbers, for all files, including intermediate and work files;

(11) Listing of all files by identifying name, showing input and output with cross-reference to program identifications;

(12) Facsimiles or reproductions of all reports generated by the modules;

(13) Instructions for requesting reports must be presented with samples of input documents and/or screens;

(14) Narrative descriptions of each of the reports and an explanation of their use must be presented;

(15) Definition of all fields in reports, including a detailed explanation of all report item calculations; and

(16) Desk level procedures.

e. Documentation must include a data element dictionary that shows, for each data element:

(1) Unique data element number;

(2) Standard data element name;

(3) Narrative description of the data element;

(4) List of aliases or technical names used to describe the data element;

(5) Cross-reference to the corresponding FMMIS/DSS entry in the Federal General System Design (GSD) document;

(6) Listing of programs using the data element, describing the use as input, internal, or output;

(7) Table of values for each data element;

(8) Data element source; and

(9) List of files containing the data elements.

f. Documentation of FMMIS/DSS must include data structures, Entity Relationship Diagrams (ERD), user manuals, business rules, and all other documentation appropriate to the FMMIS and DSS platforms, operating systems and programming languages.

User Documentation

1. The Contractor must update the user manuals for each system component and update user documentation as needed throughout the contract period;
2. During the Operations Phase, updates to user manuals must be prepared on any modifications, corrections or enhancements to the system within fifteen (15) calendar days of the State's approval of implementation of the change;
3. The Contractor is responsible for providing to the State complete, accurate, and timely user documentation of the operational FMMIS/DSS. Six (6) hard copies of such documentation must be provided to Medicaid Contract Management in final form within sixty (60) calendar days prior to the beginning of the Operations Phase. In addition to the hard copies, all systems documentation must be maintained online with access by State authorized personnel. The electronic version of the system documentation must be posted to the Web site within three (3) workdays of approval. State personnel must have the capability to print pages, selections, or entire user manuals;
4. Any changes made to FMMIS/DSS during the Contractor's contract period must be documented according to the standards described below. Updated user documentation must be provided to Medicaid Contract Management within fifteen (15) calendar days of State approval of the system change for implementation;
5. The following standards will apply to FMMIS/DSS documentation:

   a. User manuals must be written and organized so that users that are not data processing professionals can learn to access and interpret online screens;

   b. User manuals must provide a base document upon which user training materials may be built;

   c. User manuals must contain a table of contents and indices;

   d. User manuals must be organized into logical segments and presented in a logical format. All online inquiry functions must be presented separately from updating instructions;

e. All functions and supporting materials for file maintenance (for example, coding values for fields) must be consolidated by module and by file within the business functional area;

f. Instructions for file maintenance must include both descriptions of code values and data element numbers for reference to the data element dictionary;

g. The user manual for each business functional area must contain illustrations of screens and input forms used in that business functional area, with all data elements on the screens and input forms identified by the name and number;

h. Instructions for entering online updates must clearly specify the screen to be used;

i. Descriptions of online error messages for all fields incurring edits must be presented with the corresponding resolution of the edit;

j. Definition of codes presented in various sections of a user manual must be consistent; and,

k. Mnemonics used on screens and reports, in instructions, and in the data element dictionary will be consistent and identified.

Software Development Documentation

All changes to FMMIS/DSS must be documented at the various stages of development. The Contractor must provide all documents for proper Project Management and information technology development described in Section 50.4.

40.1.3.13 Continuous Business Process Improvement

It is imperative that the State stays abreast of cutting edge technology in order to take advantage of system architectures and Web technologies to provide an economical and flexible system. Therefore the Contractor must submit a plan to meet this objective for State approval. The Contractor's Continuous Business Process Improvement Plan must be updated yearly and submitted to the State by the end of each State Fiscal Year for approval. The plan must address how the following initiatives will be met:

1. The system should increase automation and system integration and decrease reliance on manual processes as much as possible. This will necessitate a regular plan to upgrade State information technology equipment on a periodic basis to keep automated technologies current and the business requirements for efficient operation. The State assumes an average effective life for most IT equipment of four years; and
2. The system should have mechanisms for ongoing modernization and upgrades to replace the historical focus on system remediation and fixes. The Contactor must have a process to analyze the technological maturity of the system and implement solutions that have increased flexibility and a broader scope.

40.1.3.14 State Training Requirements

A high priority is placed on the training of State FMMIS/DSS user staff. The State must approve all training materials, training plans, and training manuals. The

Contractor must meet the following requirements for the training of State-designated users.

1. The Contractor must provide individualized training to all State designated users authorized to access, view, and use the system in the use of all components of FMMIS/DSS and any supporting components. The Area Office staff and other business partners, as determined by the State, must have the same training made available to them as the State's onsite staff. Contractor training requirements include:

   a. Develop or use a COTS product to create and present online training courses and track student enrollment and progress;

   b. Produce PowerPoint™ or similar materials for classroom course presentation or hard copy publication for all courses;

   c. Provide a dedicated training room with appropriate equipment for use in training of State FMMIS/DSS staff in the use of the system, including interfaces;

   d. Provide the State with a detailed training plan and curriculum on how users will be initially trained and how ongoing training will be managed, including training of newly hired State staff;

   e. Provide training staff as required in Section 50.2;

   f. Train Area Office staff according to the Training Plan as approved by the State in the use of FMMIS/DSS;

   g. Post training schedules on the Web sites;

   h. Provide a forum to allow users to submit questions concerning FMMIS/DSS use and provide responses to those questions; and

   i. Provide training to all State staff when new updates are made to FMMIS/DSS.

40.1.3.15 Provider Training Requirements

The successful implementation of FMMIS/DSS depends on the ability of providers to successfully adopt and utilize the new provider functionalities of FMMIS/DSS. The Contractor must develop a Provider Training and Adoption Plan to establish how providers will be educated and trained in the new features and capabilities of FMMIS/DSS, including the provider Web portal for provider enrollment, eligibility verification, claims processing and general inquires. In addition, provider training will need to include detailed information regarding changes and new processes for provider payment and adjustments, including explanation of remittance voucher and Web-based inquiry regarding payment status.

40.1.4 Deliverables Standards

The Contractor must meet specific requirements for all deliverables in all phases of this contract. Deliverables are itemized in Section 50 for all phases except the Operations Phase. Minimum contents for certain deliverables are summarized in the table at Section 50.4.3.13. All deliverables shall use media, formats, and contents approved by the State. The State encourages the use of iterative development in a cooperative and participatory environment, in which the State may give immediate feedback on

prototypes, design concepts, and early document drafts. The State hopes to speed development through this participatory process, and minimize misunderstandings concerning business and technical requirements.

1. The Contractor must conduct participatory meetings with State staff as documents are drafted and business and systems requirements are being ascertained, including concept discussions, design prototyping, Joint Application Design (JAD) sessions, and meetings for requirements gathering and to receive State feedback on design and documents;
2. The Contractor must be open in communication during the development of documents and systems. The Contractor must provide document drafts and allow State review of programs, screens and design concepts at any stage of development at the State's request;
3. The Contractor must render all designs and itemized deliverables in writing for formal approval, in a format agreed on by the State and the Contractor as part of the Project Management process. State approval will be streamlined for items in which the State was involved at earlier stages;
4. The Contractor must supply professional deliverables, with proper spelling, punctuation, grammar, tables of contents and indices where appropriate and other formatting as deemed appropriate by the State. The deliverable document must meet the business requirements it is intended to fulfill. Documents must be easily readable and written in language understandable by State staff knowledgeable in the area covered by the deliverable. The State reserves the right to reject any deliverable that does not meet these standards. The Contractor may not consider any deliverable complete before it is accepted formally by the State;
5. All deliverables and correspondence produced in the execution of this RFP must be clearly labeled with, at a minimum, project name, deliverable title, deliverable tracking or reference number, version number and date; and
6. The Contractor will conduct walk-throughs of deliverables at stages during the development of documents and systems. A final walk-through will be conducted at the delivery of the final deliverable.

40.1.5 Standards for MITA Architecture Components

The Contractor must utilize tools that are flexible and reusable for various functions. MITA architecture standards are based on a modular componentized design approach that allows for interoperability across components and with external applications and data sources. In each area, the Contractor must select or develop tools that are proven in their class, can be purchased or licensed for use beyond the term of this contract and by other states. The Contractor must identify tools to be used with the proposal and include information on the quality of the tools for State use in scoring the proposals.

If the Contractor proposes to communicate, maintain or process Florida Medicaid data or claims using any multi-client system (a system supplied by the Contractor to operate Florida Medicaid and other customers), the Contractor must make provision to allow the State to approve any changes to the core multi-client system before they are made, and such changes must be specifically tested for impact on Florida Medicaid before they are made. The State must be allowed to participate in any CSR process operated by the Contractor on any multi-client system.

40.1.5.1 Service Oriented Architecture (SOA)

The Contractor must employ a Service Oriented Architecture (SOA) to take advantage of COTS products and allow for the reuse of system functionality among the various business functions. Service-oriented architecture (SOA) is an approach to loosely coupled, protocol independent, standards-based distributed computing where software resources available on the network are considered as Services. The SOA should feature:

1. Technology Independence: The service components must be able to be invoked from multiple platforms and utilize standard protocols;
2. Standards-based Interoperability: Support multiple industry standards, including JMS, XML, XSLT, JCA, J2EE and .NET technologies;
3. Life-cycle Independence: Each service component should be able to operate in a separate life-cycle;
4. Loose Coupling: The Service Consumer Component must define its specification independent of the Service Provider Component. The responsibility of aligning the two specifications is up to the interface component, which bridges the gap between two components;
5. Invokable Interfaces: The Service interfaces must be able to be invoked locally or remotely;
6. Communication Protocol: A Service must be able to be invoked by variety of protocols. The choice of protocol must not restrict the behavior of the service. Binding to a specific protocol must take place at run-time/deployment-time, and not at the design or development time;
7. Message Broker: Must include a message queuing system using industry standard specifications for messaging such as Simple Object Access Protocol (SOAP) or Java Messaging Service (JMS);
8. Rule driven: Services must perform specific tasks based upon business rules. Fundamental to the Service-oriented approach is a separation between the business requirements and logic, defined in the form of business processes and rules and the technology, consisting of the infrastructure that underlies the Services layer of abstraction;
9. Flexible: The Contractor must focus on the business processes that comprise FMMIS/DSS with the following in mind:
    a. Ability to adapt applications to changing technologies;
    b. Easily integrate applications with other systems;
    c. Leverage existing investments in desired legacy applications; and
    d. Quickly and easily create a business process from existing services.
10. Metadata Management: SOA architecture commonly provides application and data integration via an abstraction layer. Given the requirements of interoperability and independence, the proper use and management of metadata is extremely important to the effective operation of the SOA.

40.1.5.2 Rules Engine Requirements

The Contractor must employ a COTS, state-of-the-art business Rules Engine or Business Process Management software to record business rules for many business functions, such as provider enrollment, Benefit Plan administration, claims processing, and Service Authorizations. The Rules Engine may be useful for any process in which technical rules need to be entered, presented and analyzed by non-technical Contractor or State staff. In most cases, the State requires access to the Rules Engine to set rules of FMMIS/DSS operation. The Rules Engine must allow Medicaid policy changes to be entered into FMMIS/DSS more quickly and usually without programmer intervention. The Rules Engine must:

1. Allow for rules to be implemented in a real-time enterprise environment and applied immediately, if desired;
2. Provide a graphical front-end to the Rules Engine enabling users to easily connect and apply rules;
3. Be structured in a module concept so the same Rules Engine can be used by different services or be called as a service itself;
4. Provide a debugging process that automatically analyzes and identifies logical errors (i.e., conflict, redundancy and incompleteness) across business rules;
5. Allow for rules to be tested against production data prior to installation;
6. Contain a process for built-in rule review and approval process that will identify any conflicts in business rules as they are being developed;
7. Allow for the tracking and reporting of rules usage;
8. Produce documentation regarding all business rules; and
9. Integrate with other components in a SOA environment.

40.1.5.3 Workflow Management Engine Requirements

The requirements of FMMIS/DSS include the implementation of technology to improve communication processes. This is a fundamental element in the implementation of Continuous Business Process Improvement responsibilities by the Contractor (as outlined in Section 40.1.3.13, Continuous Business Process Improvement). The Contractor must provide an automated workflow management solution that meets the following requirements:

1. Provides a single repository of all provider and recipient contact, including linking images of all incoming correspondence to the appropriate provider/recipient number. All correspondence will be automatically date stamped for reference:
    a. Track and retain an image of all outgoing correspondence to providers and recipients;
    b. Track and image all correspondence, including State memos, between the State and the Contractor;
    c. Accommodate the receipt and tracking of requests or inquiries via telephone, fax, or email; and
    d. Accommodate searches by characteristics such as service type, name of provider, provider number, name of recipient, recipient number, Service

Authorization number, category of service, clerk identification, and any combinations thereof.

2. Provides the capability to input requests/inquiries into the workflow/imaging application to enable processing to be automated and forwarded to designated work queues and processed according to specified business rules:
   a. Move requests to the next work queue based on expertise required for completion. For example, transplant Service Authorizations would be moved to the designated transplant specialist;
   b. Allow the assignment or routing of tasks by the user;
   c. Support the tracking and resolution of contacts, including calls, on-site visits, override requests, prior approvals, and written inquiries; and
   d. Provide tickler and/or to-do list capability.
3. Accommodates the entry of notes:
   a. Notes should have a date/time stamp and identify the user entering the notes;
   b. Size and number of notes should be unlimited;
   c. Provide the assignment of a type or category to help users in searching for notes related to a specific event or topic;
   d. Type or category must be table-driven and user-maintainable; and
   e. Provide method to designate certain notes as confidential and restrict access to notes to authorized users.
4. Provides convenient, instant access to current and historical information without requiring a separate sign on beyond the initial FMMIS/DSS sign on;
5. Produces status reports and processing statistics;
6. Provides for a graphical interface to support the development and maintenance of the business processes. Allow users to create a visual capability or flowchart that controls the sequencing of manual and automated tasks performed throughout the business cycle; and
7. Capable of Integrating with a Rules Engine as a service in an SOA environment, unless a Rules Engine is already part of the Business Process Management (BPM) scope.

40.1.5.4 Automated Letter Generation

The Contractor must provide a method of automatically generating letters to providers, recipients, and other stakeholders:

1. The automated letter generator must:
   a. Provide the functionality to send letters by mail, email or fax;
   b. Provide the ability to trigger letters automatically based on processing, such as provider enrollment;
   c. Initiate system-generated letters to recipients and providers based on status in the workflow management queue. For example, the system would

generate second notices to providers who have not returned the required documentation;

d. Allow user to generate a single letter immediately;

e. Allow user to designate address to be used;

f. Support the generation of letters for mass mailings;

g. Support the use of letter templates that are easily updated including Agency letterhead and signature blocks;

h. Provide version control of letter templates;

i. Allow users to insert free form text as necessary. Freeform text should not be limited in size; and

j. Allow imposition of security rules to control who may issue each kind of letter, and to designate and enforce a chain of review for certain letters.

2. Allow for the retrieval and reproduction of all generated letters, including the address to which the letter was sent.

40.1.5.5 Web Portal

The Contractor is required to provide Web portals for use by the State staff and providers, and other interested parties. The Contractor's Web portal must have the functionality to:

1. Provide a navigation portal that all users can easily understand. The portal must be secure but not complicated to use, and not require multiple sign-in steps;
2. Allow for easy navigation between screens through Help menus, for instance a provider is inquiring on service limits. Instructions must be provided to point the provider to the appropriate handbook containing this type of information;
3. Support the ability to receive and respond to secure and HIPAA compliant emails from providers;
4. Be browser-independent and operate for most functions regardless of browser brand, as long as the browser has broad usage (at least 500,000 users nationally) and the version is recent in publication (within the last four years). Web-based claims submission and correction may require use of the State-standard version of Internet Explorer ™;
5. Provide Contractor or State staff contact information and offer interactive online support. This will allow the Contractor or State staff the capability to respond to online provider questions;
6. Provide the ability to post announcements or alerts that are displayed at user sign-on. Users should be required to acknowledge the announcement so that it is not repeatedly displayed at subsequent sign-on;
7. Maintain archives of posted announcements and non-provider specific alerts including the date and message;
8. Provide for the creation and processing of online surveys by the State or the Contractor;
9. Be HIPAA compliant;

10. Provide State Area Offices with their own Web site or a link to their Area Office through the Contractor's Web portal;
11. Provide hotlinks to frequently visited areas of the fiscal agent Web site at the State's request;
12. Provide browser-based screens with point and click and 'hovering' capabilities;
13. Provide an online tutorial functionality;
14. Provide for Computer Based Training (CBT) course presentation and record-keeping;
15. Post Frequently Asked Questions (FAQ) online organized by topic; and
16. Maintain version history for use by State legal staff of previous forms and handbooks.

40.1.5.6 Call Center Management System

The Contractor is required to provide a Call Center Management System for several functions, including provider and recipient inquiries. When toll-free call centers are used, they must include:

1. Capability to answer calls in sequence, recording and printing statistics, and indicating calls that have been placed on hold for a specific time limit;
2. Ability to integrate voice and electronic transactions into a single workflow with integrated queues that allow work blending and load balancing;
3. Ability to link contact information and processes from the Internet with processes, contact management systems and databases in the toll-free call center to ensure timely and synchronized data access;
4. Provide for email and text chat as a reliable transaction channel in addition to inbound and outbound voice calls;
5. Provide a Reader Board to visually display Call Center statistics to staff. The information reported on the board must also be available to Contractor and State management personnel via the Performance Reporting System;
6. Involve Computer Telephone Integration (CTI) to provide personalized routing and work-object handling based upon identifiers received from the caller regarding language and inquiry area and to produce reports on both electronic and voice transactions;
7. Provide multiple language options and services for hearing impaired;
8. Provide quality monitoring tools and processes to enable a continuous improvement cycle for toll-free call center services that include:
    a. Plug-in/double-jack monitoring;
    b. Silent monitoring;
    c. Record and review; and
    d. Voice and screen/multi-media monitoring.
9. The Call Center Management System must be able to monitor and provide real-time reporting and forecasting software for:

a. Abandon Rate;
b. Availability and Agent Utilization;
c. Average Speed of Answer (ASA);
d. Call length;
e. Contact Volume;
f. Customer Satisfaction;
g. Handle Time;
h. One Call Resolution Rate;
i. Peak hour statistics;
j. Identification of historical trends; and
k. Other areas as defined by the State.

40.1.5.7 Translators

The Contractor must provide a versatile COTS translator (or Enterprise Application Integration (EAI) software) and EDI mapping utility that can handle all Electronic Data Interchange and automated interface transactions under a variety of connectivity methods and regardless of computer platform. The translator must:

1. Provide translator and integrated mapping software that:
   a. Offers flexible mapping functionality supporting a variety of formats and transactions;
   b. Allows for both structure and information to be extracted directly from database tables;
   c. Provides the ability to assemble, validate, encrypt, and transport batches of data to and from providers and other interface partners;
   d. Accepts, codes, decodes and transmits all mandated HIPAA healthcare transactions;
   e. Analyzes and rejects improperly formatted HIPAA healthcare transactions; and
   f. Allows for the quick implementation of new transactions.
2. Produce custom reports regarding:
   a. Transactions submitted by transaction type;
   b. Transactions received by transaction type; and
   c. Cumulative reports over time periods to support forecasting.
3. Track and balance transactions; and
4. Retain and attach information as required by HIPAA.

40.1.5.8 Desktop Publishing Systems

The requirements of FMMIS/DSS include the implementation of technology for production of provider handbooks, policies, system documentation, training

materials, notices and other documents. The Contractor must provide a robust and standardized tool for efficient and consistent publication of quality, multilingual documents, and meet the following requirements:

1. Use a COTS product to control production of all documents.
    a. Control type, graphics, layout, and page design;
    b. Allow creation of master pages and style sheets to automate and structure documents; and
    c. Use industry standard tools to assure proper spelling, punctuation, grammar, capitalization, and to check for technical compliance with printing industry standards before publication.
2. Provide support for multi-chapter publications and long technical documents.
    a. Provide the ability to generate and insert footnotes and endnotes, generate table of contents, generate indices, include appendices, manage chapter files, and efficiently manage centralized style sheets; and
    b. Provide the ability to manage tabular material and to import tables from various data sources into controlled table structures.
3. Support distribution through printing and various electronic file formats, including Microsoft ™ Word, Adobe PDF, and HTML;
4. Support WYSIWYG (What you see is what you get) features allowing for display screen review of documents;
5. Allow for control over typographical characteristics, such as leading and kerning, and support for full color output;
6. Allow for output to be printed on site or support the production of PostScript files for printing at an outsourced print vendor; and
7. Provide for use by Contractor and State-approved staff.

40.1.5.9 Computer Based Training or Learning Management Systems

The requirements of FMMIS/DSS include the implementation of technology to train Contractor staff, State staff, providers, provider staff and others on policy, use of FMMIS/DSS and Medicaid-related operations. The Contractor must provide Computer-Based Training (CBT) tools such as a Learning Management System (LMS) to meet the following requirements:

1. Provide for simple creation of computer-based courses.
    a. Allow upload of courses from any word processor that can generate HTML formatting;
    b. Allow display of HTML-formatted text, graphics, sounds and audio-visual presentations;
    c. Allow multiple-choice quizzes at regular intervals, and provide feedback based on user responses;
    d. Allow graded testing for all courses; and
    e. Give instructions and help to users taking the CBT courses.

2. Provide for enrollment of individuals in computer-based courses:
   a. Track each person's enrollment in one or more courses;
   b. Allow for enrollment in one course based on other courses as a prerequisite;
   c. Allow secure and unique entry of users into their prescribed courses; and
   d. Allow users to take courses more than once; to review sections of a course; and to stop and start, picking up at the place where they left off.
3. Provide reporting on test questions, course progress and completion:
   a. Allow those completing a course to print a certificate of completion;
   b. Allow training managers to view reports that show overall course status; who has passed, who has failed, who has started but not finished, and who has not started a course; and
   c. Allow reports on individual test questions to determine validity and reliability and to help improve course content.

40.1.5.10 Automated, Web-based Survey Tools

The Contractor is required to provide a Windows Web-survey tool application that allows State or Contractor staff to create surveys for use by providers, recipients, stakeholders, State staff and Contractor staff. The survey tools must:

1. Provide for the easy creation of Web-based surveys:
   a. Allow simple creation of surveys by State or Contractor staff; and
   b. Allow for a variety of styles for the look of a survey.
2. Provide for quick and simple deployment of surveys as authorized by the State:
   a. Allow for email responses;
   b. Provide secure "Once-only" responses; and
   c. Provide security for the survey and responses.
3. Provide survey results and feedback to the State:
   a. Tabulate the results of each survey and present in chart or graph format;
   b. Provide accessibility to response data as a file that may be imported to Excel or other applications;
   c. Allow for responses to be viewed using pie charts, bar graphs, and in other ways; and
   d. Support reporting features that will allow for response data to be tabulated by number of completed surveys, number completed by county, district, or state.

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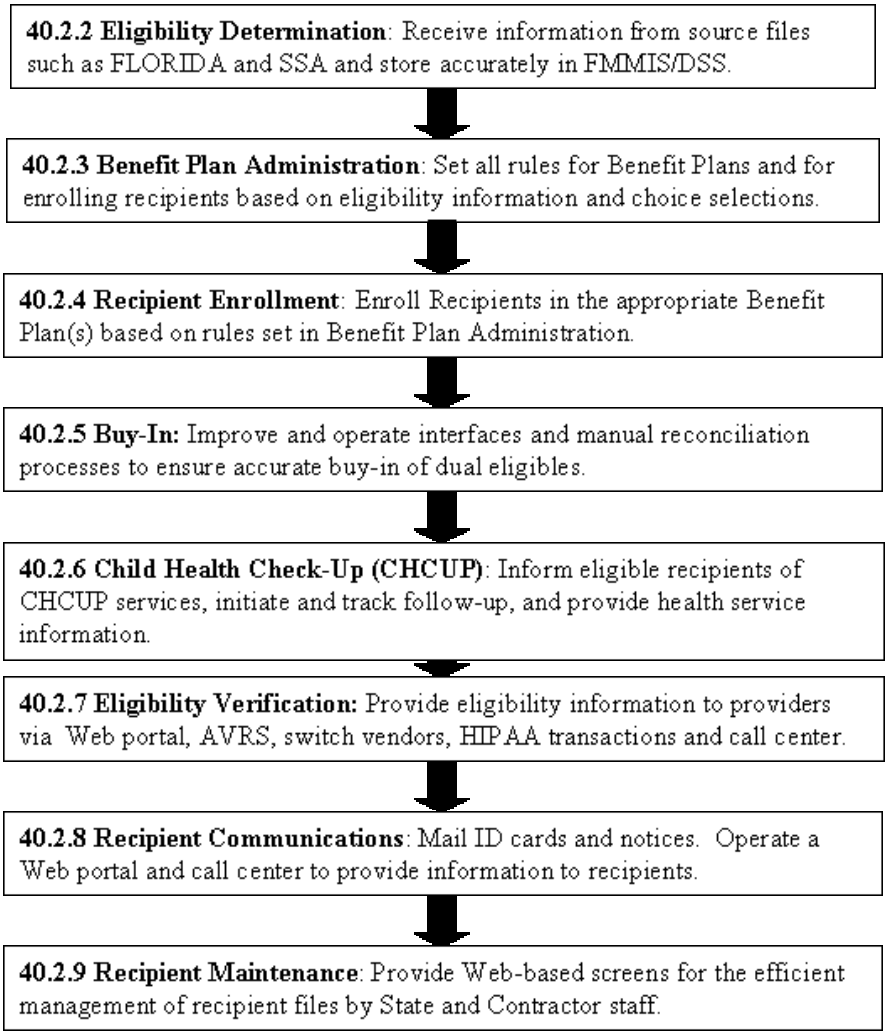
40.2 Recipient Management Business Processes



40.2.1 Introduction

The Recipient Management Business Processes encompass system capabilities of FMMIS/DSS and responsibilities of the Contractor to receive eligibility information from other agencies, use that information to place eligible recipients in appropriate Medicaid Benefit Plans, keep track of recipient-based information necessary for patient treatment, payment and operations, give eligibility and coordination of benefits information to providers, and communicate with recipients.

40.2.1.1 Recipient Management Overview

FMMIS receives eligibility information from the Florida Online Recipient Integrated Data Access (FLORIDA) System operated by the Florida Department of Children and Families (DCF), Florida Healthy Kids (FHK), other State agencies, and the Social Security Administration (SSA). The information from these source systems includes identifiers, demographics, aid categories, patient responsibility, and third party

insurance coverage. FMMIS/DSS relies on this information to determine eligibility for the various Medicaid Benefit Plans, calculate provider reimbursement, and to review and analyze utilization.

Recipient information is used in the following business functions:

- Auditing
- Buy-in
- Child Health Check-Up (CHCUP)
- Claims Processing
- County Billing
- Financial Services
- Managed Care
- Management and Administration Reporting (MAR)
- Surveillance and Utilization Review (SUR)
- Third Party Liability (TPL)

40.2.1.2 Recipient Management Objectives

The State's objectives for the Recipient Management Business Processes are to:

1. Maintain the accuracy of the eligibility information used in determining benefit eligibility and provider reimbursement;
2. Provide authorized users and providers with accurate eligibility information in a timely manner, thereby facilitating the delivery of services to eligible recipients; and
3. Provide the most appropriate care to Florida Medicaid recipients, by placing them in Benefit Plan(s) appropriate to their demographics, eligibility criteria, health condition, and relationship to the Medicaid program.

FMMIS/DSS should support these objectives through the use of innovative technology, proven processes, and methodologies designed to meet the needs of State staff and Medicaid provider and recipient populations.

40.2.2 Eligibility Determination

40.2.2.1 Eligibility Determination Overview

The purpose of the Eligibility Determination business function is to accurately record each person's eligibility status and demographic information from the various source systems. FMMIS relies on data supplied by the Florida Department of Children and Families (DCF), Florida Healthy Kids (FHK), the Social Security Administration (SSA) and others sources to determine recipient eligibility and to determine enrollment in Medicaid Benefit Plan(s).

There are two main categories of eligibility for Medicaid. These are Low-Income Families and Children, and the Aged, Blind, and Disabled. In general, DCF determines eligibility for Low-Income Families and Children and SSA determines eligibility for Aged, Blind, and Disabled. Within these categories there are various levels of eligibility. To be eligible a recipient must have met the income and asset limits required for the particular assistance category as specified by the State.

The Contractor must operate existing interfaces and create any additional interfaces to receive all information from source systems that may be necessary or useful in the

Recipient Management business process. The Contractor is responsible to maintain the accuracy of data posted to FMMIS/DSS from source files with automated and manual reconciliation processes.

40.2.2.2 Eligibility Determination External Interfaces

1. Florida Online Recipient Integrated Data Access (FLORIDA) System;
2. Social Security Administration through State Data Exchange (SDX);
3. Department of Health (DOH) for Healthy Start, Family Planning;
4. Florida Healthy Kids (FHK);
5. Florida Bureau of Vital Statistics (newborn social security numbers, date of death information); and
6. See additional inputs required for buy-in processing under Section 40.2.5.3.

40.2.2.3 Eligibility Determination Inputs

1. FLORIDA transmissions;
2. SDX transmissions;
3. FLORIDA reconciliation file;
4. SDX reconciliation file;
5. Online updates by the Contractor and State staff;
6. Batch updates by the Contractor and State staff;
7. Service limitation data;
8. Nursing home and patient responsibility related data;
9. Enrollment/disenrollment information from the HMOs, PHPs, and PMHPs and other plans of care, including mandatory assignment information;
10. MediKids eligibility;
11. Healthy Start enrollees from the Department of Health;
12. Enrollees from Waiver Agencies;
13. Children's Medical Service enrollment records form the Department of Health; and
14. Family Planning enrollees from the Department of Health.

40.2.2.4 Eligibility Determination Outputs

1. Updated FMMIS/DSS recipient files;
2. Error reports and reconciliation reports needed to synchronize FMMIS/DSS files with source files; and
3. MediKids address change file.

40.2.2.5 Eligibility Determination State Responsibilities

1. Interpret eligibility and related policy. Make all related administrative decisions and notify the Contractor of all changes in policy that affect eligibility determination;
2. Approve automated and manual procedures for recording eligibility information in FMMIS/DSS and reconciling FMMIS/DSS data with data in source systems;
3. Provide criteria for the assignment of recipient identifiers (Recipient IDs);
4. Determine criteria and hierarchy to apply to match data from multiple sources and to apply when fields in one source do not match fields from another source for the same recipient; and
5. Determine whether and when eligibility data may be archived or purged from the recipient files.

40.2.2.6 Eligibility Determination Contractor Responsibilities

1. Convert all necessary recipient data from the existing system and test thoroughly for accuracy and operability in FMMIS/DSS;
2. Develop and operate interfaces to receive information on recipients and potential recipients from source files. When available from source systems, create additional real-time transactions to update FMMIS/DSS recipient files:
   a. Analyze all outside systems interfaces during the design of FMMIS/DSS to improve and streamline the data exchange process;
   b. Maintain the integrity of recipient data, interfaces, programming, and security;
   c. Maintain recipient data, including all designated original source data and all other data that is necessary to manage all of the business functions of FMMIS/DSS. This will include all data needed for the buy-in process from any and all of the source files identified in Section 40.2.5. This will also include information on Benefit Plan enrollment, service limitations, patient responsibility information, and notes received electronically or entered by State and Contractor staff;
   d. Retain fields from source files and allow editing to systematically link individual recipient information with case/family members;
   e. Track the source, date of receipt and status of key fields in the recipient records to help reconcile potential duplicates and to assure FMMIS/DSS has the most current and correct information. Maintain indicators to confirm whether the social security number has been validated by the source system;
   f. Retain and relate all identifiers and pertinent information for each person, even if multiple records are received from the benefit agencies;
   g. Receive and process data from all input sources at least daily, on a schedule approved by the State:
      (1) Receive data from all sources listed in Section 40.2.2.3; and
      (2) Receive data from other sources identified by the State and Contractor during the Design and Development Phase or during operations.
   h. Create algorithms to integrate data from multiple sources without duplication;

i. Assign and record a unique recipient identifier to each Medicaid recipient;

j. Use a consistent, State approved algorithm to generate check digits as a part of the recipient ID;

k. Create methods to resolve accidental creation of multiple identifiers. FMMIS/DSS must have the capability to merge history files and duplicate files at the direction of the State. The files must be linked in a way that all transactions (such as claims and Service Authorizations) for the recipient are integrated;

l. Maintain multiple address records with corresponding begin and end dates and a method to identify the address type (e.g. mailing address, residence address, correspondence address, etc);

m. Use zip code validation software to help validate addresses;

n. Record language preference from the FLORIDA system and other source data available, and allow overriding preference to be set and retained by the State;

o. Record head of household and payee information from FLORIDA and other source files, and allow usage to be controlled by rules set by the State; and

p. Reject records based on rules supplied by the State and report on reconciliation and error reports to be worked manually.

3. Develop automated reconciliation processes to assure accuracy in the comparison of FMMIS/DSS files to source files:

   a. Perform automated reconciliations with the source systems at a frequency specified by the State to maintain accuracy;

   b. Resolve error reports and discrepancy lists produced from sampling and reconciliation activities;

   c. Communicate necessary source file changes and discrepancies by electronic file, email, or other automated procedures;

   d. Use record sampling and other methods on a regular basis to provide quality control and assure that Medicaid recipient data remains synchronized with the data in the source systems; and

   e. Work with the Department of Children and Families to develop ways to improve interoperability with the FLORIDA System through TCP/IP transactions or shared security access.

4. Develop and employ manual procedures to receive eligibility information from sources where an electronic interface is not yet available:

   a. Image all paper documents and make available to FMMIS/DSS State and Contractor staff by hypertext link from appropriate screens;

   b. For manually processed updates to recipient files, provide sufficient data entry staff to key in eligibility data from documents submitted by the State within three (3) workdays of receipt;

   c. Return to the State within two (2) workdays any input documents that cannot be keyed under procedures approved by the State;

d. Communicate necessary source file changes and work with source agencies and Agency Area Offices to resolve discrepancies by telephone, email, fax and written correspondence;

e. Notify the State within one (1) workday of discovering erroneous data, inconsistent data, or processing problems; and

f. Create automated process activity reports for State monitoring of this process.

5. Purge recipient records using the criteria established by the State;

6. Provide efficient, Web-based screens for State and Contractor staff to view, add, and edit recipient eligibility information:

   a. FMMIS/DSS must provide efficient means to view all recipient eligibility categories quickly, regardless of source;

   b. FMMIS/DSS must allow users to establish emergency eligibility and enter the information online; and

   c. FMMIS/DSS must log and track all changes to recipient files.

7. Create and operate an electronic interface to transmit address changes to MediKids at least daily; and

8. Monitor quality and work toward continued quality improvement:

   a. Provide information from reviewers independent of the staff performing the Eligibility Determination function;

   b. Report on quality compared to previous periods through the Performance Reporting System;

   c. Report specifically on:

      (1) Manual and automated eligibility updates;

      (2) Reconciliation processes; and

      (3) Other items as determined by the State.

   d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

   e. Document and implement corrective action plans when requested by the State.

40.2.3 Benefit Plan Administration

40.2.3.1 Benefit Plan Administration Overview

Benefit Plan Administration is a new concept for this contract, based on the State's initial steps toward MITA compliance. The business process defines criteria for enrollment, services and limitations, pharmacy benefit limitations, authorization requirements, provider networks, premium collection requirements, co-pay and coinsurance requirements, and fee structures must be more automated, using a Rules Engine to make the process more efficient.

FMMIS/DSS must use a benefit package design to allow State users to define the coverage for various programs, waivers, managed care plans, and third party coverage. In this RFP, each benefit package will be referred to as a Benefit Plan. Recipients may or may not be in more than one Benefit Plan at the same time. For example, a recipient may be in MediPass, but receive mental health services under a waiver program at the same time. Another recipient may be locked in to an alternate services care network that precludes any other coverage. Another recipient may be in a Benefit Plan that requires pre-payment review of all claims.

The Contractor must create a Benefit Plan Administration system using a Rules Engine that allows flexible definition for the creation and operation of each Benefit Plan. The rules will be based on any recipient eligibility information, provider and provider network information, and claims information. The rules will define payment methodologies. Payments to the same provider may be different based on the Benefit Plan of the recipient at the time of service.

Benefit Plans must be date-based, so that rules for enrollment and operation of a Benefit Plan may change from one time period to the next.

The Benefit Plan Administration business function of FMMIS/DSS must:

- Maintain a system to uniquely identify each Benefit Plan;
- Maintain user-defined plan characteristics (who may be enrolled into a plan, what services are in the plan, restrictions, and Service Authorization requirements, whether or not the plan is exclusive, payment methods under the plan, etc); and
- Allow authorized Contractor and State staff access to modify requirements for Benefit Plans based on date ranges.

40.2.3.2 Benefit Plan Administration External Interfaces

None at this time.

40.2.3.3 Benefit Plan Administration Inputs

Data entered into the Rules Engine by Contractor or State staff may include information in six categories. The data elements below are examples, and do not include all of the data possibilities. Full definition of all options will occur during the Design and Development Phase.

1. Plan-based information may include plan name, plan categories, enrollment requirements, enrollment limitations, geographic area of plan coverage, eligible providers to participate in or operate the plan, economic limitations, funding restrictions, service limitations, and coverage limitations. Waivers must also be tracked in a matrix in the Benefit Plan Administration Rules Engine;
2. Recipient-based data may include identification number(s), age, birth date, race, ethnicity, district, county, zip code, address, assistance categories, choice selections, level of care required, health status, Medicare status, waiver program enrollment, patient responsibility status, premium responsibility and status, lock-in, and third party resources;
3. Provider-based data may include identification number(s), provider type, geographic area, provider specialties and categories of service, provider network affiliation(s), fee schedules, and provider restrictions;

4. Claims-based data may be used both as a plan enrollment criterion and as part of the coverage rules or limitations. Claims-based data may include covered benefits, benefit limitations, dates of service, locations of service, diagnosis codes, procedure codes, and appropriation codes. For example, claims information may be used as a criterion to determine eligibility in a disease management program. Claims-based data that shows compliance or lack of compliance with specified health care treatments, such as immunizations, pre-natal visits, disease management care plans, may be used to enroll or disenroll a recipient from a particular Benefit Plan;
5. Reference-based information may include diagnosis-related group (DRG), therapeutic class, and standard patterns of care; and
6. Other data includes other coverage and Service Authorizations.

40.2.3.4 Benefit Plan Administration Outputs

Rules to be used in the Recipient Enrollment process.

40.2.3.5 Benefit Plan Administration State Responsibilities

1. Use a Benefit Plan Administration System supplied by the Contractor to create the hierarchy of rules for the creation and operation of benefit plans and for Recipient Enrollment into the Benefit Plans. Alternatively, supply the Contractor with the hierarchy of rules for the creation and operation of benefit plans and for Recipient Enrollment into the Benefit Plans.
    a. Define all the Benefit Plans to be used in FMMIS/DSS based on any input criteria described in Section 40.2.3.3;
    b. Define and maintain Benefit Plans for recipients in each waiver program;
    c. Approve updates to Benefit Plans proposed by the Contractor; and
    d. Respond to Contractor questions related to covered services.
2. Manage the Benefit Plans:
    a. Initiate and monitor systems changes for covered services for State health care programs;
    b. Review and approve all public information related to State health care programs;
    c. Negotiate with CMS concerning terms and structure of waiver programs;
    d. Contract with HMOs, provider networks, special managed care programs and other service providers; and
    e. Set fees and rates to be used for each benefit plan.
3. Inform the Contractor of revisions in policies related to benefit-related coverage so they are reflected in provider/recipient handbooks, billing manuals, and other program documentation; and
4. Define content, format, frequency, and media for reports.

40.2.3.6 Benefit Plan Administration Contractor Responsibilities

1. Develop or use a COTS package to control the rules of Benefit Plan Administration, to be called the Benefit Plan Administration System.
    a. Support the administration of a variety of service delivery models, including but not limited to, full-risk capitation, primary care capitation, physician case management, MCO agreements, vendor contracting arrangements, and utilization controlled fee-for-service arrangements;
    b. Support a matrix of waiver programs and create Benefit Plan rules to accommodate each waiver program or category;
    c. Accommodate recipient eligibility in multiple programs with overlapping begin and end dates. Benefits from one program may supersede or have precedence over benefits for another program. All segments must be viewable online and available for processing;
    d. Provide for Benefit Plan definitions to include and record rules based on any input criteria described in Section 40.2.3.3;
    e. Provide the flexibility to quickly and easily accommodate Benefit Plan changes;
    f. Allow benefit plans to change from date to date, and must be able to apply plan rules in effect for the date of service;
    g. Provide mechanisms that allow State staff or automated rules to lock-in a recipient to a certain pharmacy, MCO or other provider for certain services, and deny all claims in a category for that recipient from other providers; and
    h. Provide the ability to enroll recipients into benefit plans according to the hierarchy of rules on a schedule approved by the State. This functionality must replace and exceed capabilities of functions operated in the State's current MMIS, including the monthly Managed Care Processing Cycle and the Mandatory Assignment System. Information on these processes is in existing system documentation in the Medicaid Procurement Library.
2. Maintain and operate the Benefit Plan Administration System, and provide Web-based access to the system for Contractor and State use:
    a. Provide authorized State users with online access to view and edit Benefit Plan information;
    b. Create Benefit Plans for new programs as specified by the State. Edit Benefit Plans at the direction of the State;
    c. The system must allow users to test Benefit Plans prior to implementation in production; and
    d. Make, test and troubleshoot entries into the Rules Engine to assure operation that accurately parallels the existing FMMIS.
3. Train Contractor and State users in the creation of Benefit Plans under the Benefit Plan Administration System and in the use of the Rules Engine to set the hierarchy of Recipient Enrollment;

4. Maintain the benefit package associated with each Benefit Plan, including the resulting rules that may apply to provider enrollment, claims processing, reporting, and any other implications to FMMIS/DSS;
5. Generate reports on the structure of the Benefit Plans to help the State set the Benefit Plan rules more efficiently; and
6. Study and analyze all relevant programs and operating procedures in the current FMMIS as it is being operated during the period of the Design and Development Phase, including all relevant Customer Service Requests and contract amendments:
   a. Formulate the initial business rules for this business process based on the current MMIS operations;
   b. Submit the proposed rules to the State for approval;
   c. Enter those rules approved by the State into the Rules Engine; and
   d. Test the rules to assure they process as expected, compared to current FMMIS operations.
7. Monitor quality and work toward continued quality improvement:
   a. Provide information from reviewers independent of the staff performing the Benefit Plan Administration function;
   b. Report on quality compared to previous periods through the Performance Reporting System;
   c. Report specifically on:
      (1) Changes to Benefit Plan structure or addition of Benefit Plans;
      (2) Performance of the Benefit Plan Administration System; and
      (3) Other items as determined by the State.
   d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months;
   e. Document and implement corrective action plans when requested by the State; and
   f. During the Readiness Testing Period, demonstrate the accuracy of rules application by proving the comparison to current fiscal agent operations; document and explain any differences to the satisfaction of the State.

40.2.4 Recipient Enrollment

40.2.4.1 Recipient Enrollment Overview

In the Recipient Enrollment business function, the Contractor must maintain the system for Recipient Enrollment and accurately assign and record each recipient into one or more appropriate Benefit Plans based on Benefit Plan definition, eligibility information, managed care choice selections, provider information, claims information, reference and other information and rules set by the State in Benefit Plan Administration. Through the mandatory assignment process, recipients who have not chosen a Managed Care Organization (MCO) or Primary Care Provider

(PCP) are systematically assigned as part of the Recipient Enrollment business function. Enrollment of unborn or newborn recipients is also included in this business function.

Currently Florida residents not eligible for Medicaid do not have the option of purchasing Medicaid coverage; however, this may be implemented in the future. Therefore, the new system will need to support this activity as part of FMMIS/DSS.

Some enrollment information is a matter of recipient choice; the rest must be assigned by FMMIS/DSS based on the rules set by the State in the Benefit Plan Administration process (See Section 40.2.3). The Contractor must operate a Choice Counseling Unit to assist recipients in their selection of care options and Primary Care Provider. The Choice Counseling Unit will be responsible for outreach to recipients and receipt of telephone calls and written correspondence from recipients for managed care selection. The Choice Counseling Unit will serve as an Enrollment Broker Unit to ensure that Medicaid recipients required to enroll in a managed care plan or MediPass receive timely, unbiased and adequate information regarding their health plan options.

The choice counseling and enrollment broker services are a major activity under the contract. The Vendor must consult the Medicaid Procurement Library to assure that, in addition to the specific requirements described in this RFP, the functions in the current Managed Care and Medipass Enrollment Services contract will be addressed and fulfilled by the Contractor.

The Contractor must operate toll-free telephone service to respond to recipient inquiries about their choices. The Contractor must provide a Web portal for recipients to receive choice information and make choice selections.

FMMIS/DSS must also record the Primary Care Provider within certain of its networks and service options. For example, a recipient may be assigned to a MediPass Benefit Plan, with a certain doctor as his/her Primary Care Provider.

40.2.4.2 Recipient Enrollment External Interfaces

1. MediKids eligibility and enrollment files (In the current FMMIS, this is a batch and manual process. The Contractor must work with the State to improve and automate this process.);
2. HIPAA 834 Enrollment Transactions received from MCOs, waiver providers, Pre-paid Mental Health Plans (PMHPs) and others;
3. Medicare enrollment (See Section 40.2.5, Buy-in);
4. Web portal for recipients to access general information, choice options and to make choice selections; and
5. Telephone toll-free call center to receive recipient calls for choice counseling and enrollment broker functions (See Recipient Communications, Section 40.2.8)

40.2.4.3 Recipient Enrollment Inputs

1. Florida Healthy Kids Corporation (MediKids) enrollment information;
2. Family Planning waiver input documents from the Department of Health;
3. Primary Care Provider selections and assignments;

4. Choice selections made by recipients;
5. Unborn recipient activation forms;
6. Healthy Start enrollment information from the Department of Health;
7. HIPAA 834 enrollment transactions;
8. FMMIS eligibility information (See Section 40.2.2);
9. Children's Medical Service enrollment records form the Department of Health; and
10. Business rules set by the State (See Section 40.2.3).

40.2.4.4 Recipient Enrollment Outputs

1. Communications to recipients concerning their enrollment options;
2. Recipients properly enrolled in Benefit Plan according to State rules;
3. Reports on enrollment and Primary Care Physician choices for MediPass and other service networks;
4. Reports on choice outreach, choice selections, and toll-free call center activity;
5. Mandatory Assignment reports;
6. Returned Family Planning Waiver input documents that cannot be processed under the rules supplied by the State; and
7. HIPAA 834 Enrollment Transactions.

40.2.4.5 Recipient Enrollment State Responsibilities

1. Set the business rules and policies for automated enrollment and mandatory assignment (See Section 40.2.3);
2. Approve manual procedures to be used by the Contractor in the enrollment process;
3. Assist the Contractor in creating or improving interfaces for more efficient processing;
4. Monitor the activities of the Choice Counseling Unit:
    a. Approve choice counseling and enrollment broker materials to be sent or communicated to recipients;
    b. Approve operating procedures and scripts for the Choice Counseling and enrollment broker toll-free call center (See Recipient Communications, Section 40.2.8);
    c. Monitor performance of the Choice Counseling and enrollment broker toll-free call center (See Recipient Communications, Section 40.2.8); and
    d. Review enrollment reports and Primary Care Provider choice reports.
5. Define content, format, frequency, and media for reports

40.2.4.6 Recipient Enrollment Contractor Responsibilities

1. Enroll Recipients in the correct Benefit Plan, based on the schedule and rules established in the Benefit Plan Administration process:
   a. Enroll new recipients at least daily, or on a schedule to be approved by the State;
   b. Produce error reports related to automated assignment and resolve errors within one workday;
   c. Assign recipients to the appropriate Primary Care Provider within a service network, if the rules require it;
   d. Notify and educate recipients of any Lock-in requirements, if the rules require it;
   e. Educate recipients about the availability of Children's Medical Services (CMS);
   f. Educate recipients about their options during the open enrollment period and assist them where necessary;
   g. Enroll unborn recipients based on criteria specified by the State, including the receipt, entry, and processing of unborn activation forms;
   h. Allow State staff to electronically generate requests to update segments for Benefit Plan enrollment:
      (1) Process electronic requests generated by State staff according to rules set in Benefit Plan Administration;
      (2) Automatically generate capitation if a segment update successfully enrolls a recipient; and
      (3) Automatically generate a void if a segment update disenrolls a recipient.
   i. Make mass transfers based on files or criteria supplied by the State.
2. Operate a Choice Counseling and enrollment broker telephone outreach program and toll-free call center to help recipients make informed choices based on options available to them under the Medicaid program. (See Recipient Communications, Section 40.2.8):
   a. Develop and implement a State-approved policies and procedures manual for the operation of the Choice Counseling Unit. Address:
      (1) Call center operational activities, including enrollment, disenrollment, plan changes, exemptions and exclusions from managed care, "good cause" change requests, HIPAA privacy and security, and handling complaints;
      (2) Processing mail, email and Web portal requests and inquiries;
      (3) Telephone scripts;
      (4) Data entry;
      (5) Quality control;
      (6) Reporting requirements;
      (7) Staff training; and

(8) Procedures to avoid fraudulent enrollment.

b. Accept, store, and provide for Choice Counseling Unit reference information from MCOs regarding their provider network, whether the providers are enrolled as Medicaid providers or not:

(1) Work with the State and the various MCOs to create electronic formats to receive network provider information at least twice per month; and

(2) Provide the reference in searchable Web pages that make it easy for telephone inquiry specialists to give correct and unbiased information.

c. Produce and mail Choice Counseling and enrollment broker outreach materials, and revise such materials at the direction of the State;

d. Mail open enrollment notification letters at least sixty (60) calendar days prior to the beginning of the open enrollment period;

e. Provide each new managed care eligible recipient, including the payee of the family, with written information, approved by the State, to assist in plan choices;

f. Screen children for potential eligibility in Children's Medical Services programs operated by the Florida Department of Health using criteria to be supplied by the State, and refer them to State staff as appropriate for more information;

g. Train telephone inquiry support staff and all other staff that will receive and process choice counseling or enrollment brokering calls through the use of State-approved materials and courses. Emphasize in the training materials the importance of objectivity toward all plans, respectful treatment of all callers, and sensitivity to caller privacy;

h. Assure that telephone inquiry support staff do not recommend one plan over another;

i. Provide sufficient bilingual (English and Spanish) staff to effectively communicate with the Medicaid recipient population;

j. Provide alternate forms of communication for recipients with visual impairments, hearing impairments or limited reading proficiency;

k. Provide recipients who enroll, disenroll or change their managed care plan or MediPass PCP by phone or written confirmation within three (3) workdays;

l. Establish an automated mailing, telephone and returned mail tracking system to ensure timely choice selections and change of choices;

m. Subscribe to restriction of activities based on the "List of Prohibited Activities" for the enrollment broker found in the current Choice Counseling contract (See the Medicaid Procurement Library);

n. Meet all independence requirements for enrollment brokers set in 42 CFR 438.810;

o. Maintain an average monthly telephone call handling error rate of less than three (3) percent, as determined through State-reviewed quality control monitoring;

p. Maintain an average monthly enrollment error rate attributable to the enrollment broker function of less than three (3) percent of the total number of enrollments, disenrollments and plan changes processed by the Choice Counseling Unit; and

q. Employ a State-approved method to verify recipient identity before information is discussed with the inquirer.

3. Operate a recipient Web portal to allow recipients to make choice selections online;

4. Receive and process updates to enrollment based on telephone, secure and HIPAA-compliant email, Web portal or written choice selections, HMO and other MCO transactions and information received from MediKids, including a record of the Primary Care Provider:

   a. Process all enrollment updates and choice selections within one (1) workday of receipt;

   b. Process transfers for applicants who wish to select or change MediPass providers to the local area MediPass office;

   c. Process transfers for applicants who wish to select or change managed care plans;

   d. Follow up with telephone calls, written correspondence (in English, Spanish or Creole as appropriate) or secure and HIPAA-compliant email to resolve recipient questions;

   e. Send a confirmation of choice letter (in English, Spanish or Creole as appropriate) to each recipient or parent who makes or changes the provider choice;

   f. Send follow-up letters (in English, Spanish or Creole as appropriate) to recipients, parents or guardians who do not make a choice or who need additional follow-up based on procedures approved by the State. Include return forms for choice selection;

   g. Research addresses and remail returned mail;

   h. Develop procedures to assist families with special situations, including the following examples:

      (1) The discontinuance of service by an HMO or MediPass provider;

      (2) Request by the State or Florida Healthy Kids Corporation to record choices for children not on the choice file;

      (3) Parents who receive choice letters, but no choice file exists;

      (4) Children whose coverage has begun, but the HMO does not reflect such coverage;

      (5) Callers who wish to register a grievance;

      (6) Oral interpretation services for non-English speaking recipients; and

      (7) Lost identification cards.

   i. Log all transactions to provide an audit trail;

j. Complete plan changes as required by 42 CFR 438.56 and Florida state law 409.9122(i), allowing recipients to change enrollment for a "good cause," within time frames approved by the Agency. If the "good cause" plan change is denied, notify the recipient within three (3) workdays of the denial; and

k. Develop a beneficiary satisfaction questionnaire, to be approved by the State, that may be conducted by telephone, mail or via the Web portal. Conduct a random survey of at least 200 recipients per quarter to determine the level of quality and recipient satisfaction with the enrollment and Choice Counseling process.

5. Process Family Planning Waiver Input Documents. Return to Medicaid Contract Management any Family Planning Waiver Input documents that cannot be keyed due to duplicate files or coverage information limitations.

   a. Return documents to the Department of Health that:

      (1) Are incomplete or illegible;

      (2) Include a different name, SSN, date of birth, and/or Medicaid ID of recipient indicated on FMMIS; or

      (3) Cannot be keyed due to error messages received by FMMIS, recipient not on file, invalid eligibility spans, or requested change already on file; and

   b. Send a Choice Letter (in English, Spanish or Creole as appropriate) to those who select a new provider or change their existing provider. For MediPass, the client brochure should also be sent.

6. Produce reports on choice outreach, choice selections, Medikids, enrollment broker functions, and toll-free call center activity. The following reports are examples of the kind of report that must be produced. Report formats must be approved by the State, and must be modified upon State request:

   a. Choice Letters Report: Lists those children identified as potentially MediKids eligible;

   b. Call Center Daily Activity Report: This report includes the number of calls to the toll-free call center, the number of calls answered in each category, the length of time to answer calls, and the number of calls abandoned;

   c. Enrollment Activity Reports, including plan enrollments, disenrollments, changes;

   d. Follow-up Reports, including data on the status of those who have not made choices or selections within State-prescribed timeframes;

   e. Reports on required mailings and plan confirmation notices.

   f. Enrollment Error Rate Reports, including the number of enrollments that processed without any errors;

   g. Enrollment by Plan Reports, including the number and percentage of enrollees by plan and area;

   h. Plan Changes by Plan, including the number and percentages of plan changes by plan and area;

   i. Lock-in Reports, including the number of enrollees in Lock-in;

j. Good Cause Changes and Pending Changes Reports, including the number of good cause changes approved, denied or cancelled by reason code and the number of good cause change requests pending by reason code; and

k. Any other reports deemed necessary by the State.

7. Propose a system-automated solution for capturing medical expenses for the Medically Needy, those individuals who must reach a level of medical expenditure or share of cost, before they become Medicaid eligible for the month. Use FMMIS/DSS to track this spenddown amount, establish eligibility and appropriately pay or deny claims.

8. Monitor quality and work toward continued quality improvement:

   a. Provide information from reviewers independent of the staff performing the Recipient Enrollment function;

   b. Report on quality compared to previous periods through the Performance Reporting System;

   c. Report specifically on:

      (1) Benefit plan enrollment activity;

      (2) Choice Counseling and Enrollment Broker telephone outreach program and toll-free call center activity;

      (3) Operation of the Web portal;

      (4) Enrollment update processing;

      (5) Family Planning Waiver Input Documents processing; and

      (6) Other items as determined by the State.

   d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

   e. Document and implement corrective action plans when requested by the State.

40.2.5 Buy-in

40.2.5.1 Buy-in Overview

The purpose of buy-in is to ensure that all Medicaid recipients eligible for Medicare coverage are properly enrolled in Medicare, that Medicaid pays the appropriate premiums and that all necessary Medicare information is available and accurately used to process dual eligibles, including claims payment, plan assignment and federal reporting. While most buy-in functions could be described in Eligibility Determination, Benefit Plan Administration and Recipient Enrollment, the functions of buy-in are complex enough to warrant separate consideration.

The buy-in process must be flexible, accurate and highly controlled using a Rules Engine and workflow management engine. The interfaces are complex, and use file formats and exchange protocols that must be synchronized with the federal government and the Department of Children and Families.

The Contractor must improve upon existing interfaces and create streamlined work processes to minimize the amount of manual effort involved in reconciling buy-in files. Vendors are encouraged to describe proven buy-in functionality used in other states that would be applicable for Florida.

The current buy-in process is a complex interchange of information among the Social Security Administration (SSA), the Centers for Medicare and Medicaid Services (CMS), the Department of Children and Families (DCF), and FMMIS/DSS. Data exchanges from SSA and CMS to and from FMMIS/DSS are all processed through DCF, the single State point of contact for such file transfers. DCF is also a source file for FMMIS/DSS recipient eligibility determination information. Errors discovered as Contractor or State staff work buy-in discrepancies must be communicated to DCF for correction in the FLORIDA System.

In 2002, CMS began implementation of an improved, customized means to compare dually eligible recipients, that is, recipients eligible for both Medicare and Medicaid. This process included customized extracts from the federal Medicare Enrollment Database (EDB), a comprehensive one-time file and monthly finder files. Additional ad-hoc files may be made available from time to time. The Contractor must create interfaces and procedures to receive, process and use these files to improve the efficiency of the buy-in process and accurately identify Medicare coverage for Florida Medicaid recipients.

The Contractor must create and implement methods for processing Medicare Part D during the Design and Development Phase at no additional charge to the State.

Because the buy-in process is so complex, there are special staffing and training requirements: The Contractor must name a qualified buy-in coordinator and supply a resume with the proposal; and the Contractor must provide buy-in training for both Contractor and State staff.

40.2.5.2 Buy-in External Interfaces

1. SDX (Daily Medicare eligibles from SSA);
2. BENDEX (Semi-monthly Medicare eligible recipients from SSA);
3. State Eligibility Verification System (SVES, SSA nightly batch eligibility files);
4. State Online Query (SOLQ, individual eligibility online, real-time inquiry transactions);
5. Medicare Enrollment Database (EDB) files from CMS;
6. Part A State Input File (FMMIS/DSS to CMS);
7. Part B State Input File (FMMIS/DSS to CMS);
8. Medicare Premium Files (CMS to FMMIS/DSS, results of processing enrollment files, including errors to be worked);
9. Florida Online Recipient Integrated Data Access (FLORIDA) system (Recipient master records, intermediary for all CMS/SSA file transfers); and
10. Bureau of Vital Statistics (date of death).

40.2.5.3 Buy-in Inputs

1. FMMIS/DSS recipient eligibility information;

2. SDX;
3. BENDEX;
4. State Eligibility Verification System (SVES);
5. State Online Query (SOLQ);
6. Medicare Enrollment Database (EDB);
7. Medicare Premium Files;
8. Bureau of Vital Statistics; and
9. Manual changes made by State and Contractor staff.

40.2.5.4 Buy-in Outputs

1. Updates to FMMIS/DSS recipient files, including Medicare eligibility information and reconciled identification information;
2. Part A enrollment files;
3. Part B enrollment files;
4. Part D enrollment files;
5. Files and transactions to the FLORIDA system with Medicare entitlement changes and corrections;
6. Manual communications by fax, secure and HIPAA-compliant email and telephone to DCF and SSA to communicate discrepancies and changes to the FLORIDA System and SSI recipient files; and
7. Manual communications with CMS as needed to address discrepancies and changes.

40.2.5.5 Buy-in State Responsibilities

1. Set all policies related to buy-in:
    a. Interpret eligibility and buy-in policy and make all administrative decisions concerning policy;
    b. Provide assistance to the Contractor in interpreting federal manuals and guidelines;
    c. Approve all Contractor plans, systems and procedures for operation of FMMIS/DSS buy-in components; and
    d. Approve Contractor plans for implementation of Medicare Part D requirements.
2. Establish and provide rules and schedule for automated processes to identify Medicaid recipients eligible for Medicare and buy-in, and to properly enroll and pay premiums:
    a. Make changes using the Rules Engine (See Benefit Plan Administration); and
    b. Alternatively, the State will communicate these requirements to the Contractor for entry into the Benefit Plan Administration rules;
3. Approve procedures for the Contractor to work discrepancies:

a. Approve automated interfaces, interface rules and schedules;

b. Provide access to the FLORIDA system for designated buy-in staff;

c. Approve manual processes for working error reports, communicating with State staff, and communicating with DCF; and

d. Provide technical assistance to the Contractor's buy-in staff in resolving buy-in or Medicare entitlement problems.

4. Approve training materials for teaching State and Contractor staff about the buy-in processes and operational procedures; and

5. Define content, format, frequency, and media for reports.

40.2.5.6 Buy-in Contractor Responsibilities

1. Thoroughly and continuously analyze the buy-in process to ensure efficient and maximum appropriate buy-in of eligible Medicaid recipients into Medicare:

   a. During the Design and Development Phase, the Contractor must analyze the current buy-in interface and data exchange process and recommend improvements to both the manual and automated processes; and

   b. Analyze and recommend solutions for the Medicare Modernization Act (MMA) State Data File.

2. Develop interfaces, programs and software to obtain and process Medicare eligibility information:

   a. Develop or use COTS software, such as Rules Engines, to accurately and efficiently interpret and post data from SSA, CMS and DCF;

   b. Identify potential errors with data exchange files, and create the capability to suspend transactions for unresolved problems;

   c. Use all data exchange information that is available from SSA or CMS to identify Medicare entitlement for all Medicaid beneficiaries;

   d. Identify and post Medicare entitlement to the file for use by FMMIS/DSS for all actions, such as determining who needs Medicare buy-in, managed care actions and TPL processing for claims;

   e. Keep separate data fields as necessary to distinguish Part A, Part B and Part D information needed for buy-in processing;

   f. Post current updates to recipient demographic records from the EDB files, based on rules approved by the State;

   g. Maintain identifiers, such as Medicare ID, from each source for comparison during error reconciliation;

   h. Maintain indicators to show if Medicare ID and Social Security Number have been validated by DCF;

   i. Use alternate demographic information obtained from SVES, SOLQ, or FMMIS/DSS input when allowed by State rules to override source data to facilitate more accurate buy-in;

   j. Post date of death according to State rules and assure that no buy-in premiums are paid for periods after the date of death; and

k. Create views into source file transactions, to assist Contractor and State in resolving discrepancies.

3. Receive and process Medicare Premium Files:

   a. Account for premiums paid and to be paid, based on information in the Medicare Premium Files;

   b. Obtain premium refunds from CMS for any months for which the State is inappropriately billed;

   c. Track all buy-in refunds made to the State; and

   d. Reimburse the State for payments made in error if overpayment of premiums cannot be reimbursed by CMS due to incorrect information supplied by the Contractor.

4. Resolve discrepancies in FMMIS/DSS based on information received in the Medicare Premium Files and other sources:

   a. Produce reports and report files on all discrepancies reported;

   b. Create automated and effective methods to resolve buy in discrepancies as approved by the State;

   c. Resolve all (100 percent) buy-in related errors or discrepancies in order to ensure the maximum buy-in match occurs; and

   d. Resolve all buy-in discrepancies within five (5) workdays of receipt of the error.

5. Inform DCF of discrepancies that need to be posted to the FLORIDA System based on information received in the Medicare Premium Files:

   a. Produce reports and report files on all discrepancies reported;

   b. Report discrepancies in the Medicare number to DCF for correction in the FLORIDA system on a daily basis;

   c. Work with the State to create automated files or transactions that can be sent to DCF on at least a daily basis to inform DCF of discrepancies;

   d. Report other discrepancies by secure and HIPAA-compliant email, fax, or telephone, using procedures approved by the State;

   e. Receive and work calls, secure emails, documents and faxes from DCF, State and federal staff to resolve buy-in issues within five (5) workdays; and

   f. Image all faxes and written documents and attach to FMMIS/DSS record for viewing by buy-in processing staff.

6. Provide training to State and Contractor staff on the buy-in automated and manual processes:

   a. Include training in use of the FLORIDA System to view buy-in-related information, data exchange, CMS Medicare buy-in rules, and the operational procedures for file corrections; and

   b. Provide an online training manual and operational guide and Computer Based Training (CBT) for reconciling discrepancies in FMMIS/DSS and the source files, as approved by the State.

7. Track and audit all transactions related to buy-in:
   a. Indicate the source and date of key identifiers from source files;
   b. Indicate the author, date and reason for all manual changes;
   c. Maintain a complete transaction history;
   d. Maintain the complete State buy-in history for each recipient; and
   e. Provide on-demand reports of all buy-in transactions, including a list of all buy-in actions taken by Contractor and State staff;
8. Monitor quality and work toward continued quality improvement:
   a. Provide information from reviewers independent of the staff performing the buy-in function;
   b. Report on quality compared to previous periods through the Performance Reporting System;
   c. Report specifically on:
      (1) Number of buy-in recipients;
      (2) Receipt and processing of Medicare eligibility information;
      (3) Receipt and processing of Medicare Premium Files;
      (4) Identification, resolution and communication of discrepancies;
      (5) Training activity; and
      (6) Other items as determined by the State.
   d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and
   e. Document and implement corrective action plans when requested by the State.

40.2.6 Child Health Check-Up (CHCUP)

40.2.6.1 CHCUP Overview

FMMIS/DSS must support proactive medical services for recipients under age 21 covered by the Child Health Check-Up (CHCUP) program of Florida Medicaid. Data and systems in FMMIS/DSS must be employed to detect health problems in early stages, screen for inclusion in CHCUP care, manage and track CHCUP cases, and produce reports for federal reporting and case documentation.

The purpose of these components is to:

- Identify individuals eligible for CHCUP services;
- Automate procedures to support outreach and case management functions;
- Inform newly eligible families and families who have regained eligibility about the availability and scope of CHCUP services;
- Inform non-participating families on an annual basis about CHCUP services;
- Offer support services to participating families who request screening services;

- Inform eligible families due a periodic screening, based on the State periodicity table, of the availability and scope of CHCUP services;
- Inform eligible families who require further referrals for diagnosis and treatment as a result of screening exams;
- Document services provided and actions taken to support program management and to meet the CHCUP federal reporting requirements; and
- Produce reports to ensure that services are being offered on a timely basis as specified in the CHCUP program regulations (42 CFR part 441).

The Contractor must apply algorithms supplied or approved by the State in the Benefit Plan Administration Rules Engine to identify those newly eligible for CHCUP services and those who have regained eligibility.

Once identified, CHCUP services must be coordinated through a process defined in a workflow approved by the State. The workflow will include case monitoring, automated notices offering certain services, and reports to help in case management and to document compliance with federal requirements.

The Contractor must propose a plan to make the process more efficient and to work toward measurement and achievement of better health care outcomes. The Contractor must include improved recipient interaction through the Web portal and/or telephone toll-free call centers, such as 2-1-1 centers operating in Florida.

The Contractor must develop or use a COTS workflow management engine to set the tasks in the CHCUP process. The Contractor must employ all steps set in the workflow management system to maximize the health benefits from the State's CHCUP program.

40.2.6.2 CHCUP External Interfaces

1. Web portal; and
2. Department of Health (DOH) Immunization Registry.

40.2.6.3 CHCUP Inputs

1. Paper Enrollment forms;
2. Web portal enrollments;
3. Workflow steps supplied by the State; and
4. DOH Immunization Registry.

40.2.6.4 CHCUP Outputs

1. English, Spanish and Creole notices to recipients;
2. Telephone and Web scripts; and
3. CHCUP reports.

40.2.6.5 CHCUP State Responsibilities

1. Determine all CHCUP policies and approve all CHCUP systems and procedures:
   a. Determine the content of all notices;
   b. Determine the schedule for CHCUP workflow;

c. Identify the case management schedule (the Periodicity Table) of CHCUP care for each type of case;

d. Enter the Periodicity Table into the workflow engine; and

e. Provide, as an alternative, Periodicity Table entries to the Contractor for entry into the system.

2. Contact recipients and providers to collect data for supplementary updates to recipient cases;

3. Provide additional support services to recipients as needed:

a. Use Area Office staff to follow up on recipient medical needs based on ticklers from the workflow management system; and

b. Enter data on all follow-up activities into case logs and notes.

4. Define content, format, frequency, and media for reports.

40.2.6.6 CHCUP Contractor Responsibilities

1. Create systems and data relationships within FMMIS/DSS to meet the business requirements of CHCUP;

2. Provide means within the Benefit Plan Administration Rules Engine to identify all recipients eligible for CHCUP services:

a. Allow entry of rules by State staff; and

b. Enter rules into the Rules Engine supplied by State staff as an alternative.

3. During the Recipient Enrollment process, identify eligible CHCUP recipients according to rules established under Benefit Plan Administration:

a. Identify those newly eligible; and

b. Identify those who have regained eligibility.

4. Develop or use a COTS workflow management engine to set the tasks to be tracked as part of the CHCUP process:

a. Provide for task assignment to Contractor staff, Medicaid headquarters staff and Area office staff in the workflow; and

b. Provide means for recording all case activity, including:

(1) Logs of notices;

(2) Recommended dates of service from the Periodicity table;

(3) Actual dates of services;

(4) State and Contractor contacts;

(5) Case notes; and

(6) Provide Web-based query and management screens to make it easy for State and Contractor staff to know the next steps due according to the workflow.

5. Use the workflow management engine to provide and log notices, track services provided, and enter case notes for each CHCUP-eligible recipient:

a. Automatically generate letters from the CHCUP workflow management system, according to specifications set by the State;

b. Mail program awareness promotional materials specified by the State;

c. Prepare English, Spanish and Creole versions of informing notices for State approval prior to mailing;

d. Identify the family head of house and generate Child Health Check-Up screenings letters to this individual even if the child resides at a different address;

e. Retrieve data from FMMIS/DSS claims and encounter data to compare to services recommended from the Periodicity Table;

f. Retrieve and incorporate data from the Department of Health immunization registry into the case log for each recipient;

g. Provide for the inclusion of claims attachments with links from CHCUP screens;

h. Compare fee-for-service and encounter claims to the periodicity table to determine if the child received the health checkup examination and related services at the recommended intervals; and

i. Follow-up on recipients who have requested service but for whom there is no indication of service provided.

6. Maintain a Web portal to provide information and allow recipients to submit questions:

   a. Provide program awareness and general information;

   b. Provide copies of all notices;

   c. Allow recipients to access their case recommendations and actual services on the portal;

   d. Allow recipients to enter questions about their case; and

   e. Route questions by email according to the workflow rules approved by the State.

7. Generate the required federal and State tracking reports:

   a. Conduct report design meetings with the State during the Design and Development Phase to identify all reports and data elements;

   b. Allow flexible sorting within CHCUP reports, for example: by Benefit Plan, by provider type, and by diagnosis; and

   c. Allow authorized users the flexibility to identify new data elements to be contained in the reports.

8. Monitor quality and work toward continued quality improvement:

   a. Provide information from reviewers independent of the staff performing the CHCUP function;

   b. Report on quality compared to previous periods through the Performance Reporting System;

c. Report specifically on:

(1) Identification of CHCUP eligibles;

(2) Performance of workflow management processes and systems;

(3) Performance of Web portal;

(4) Production and distribution of required reports; and

(5) Other items as determined by the State.

d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

e. Document and implement corrective action plans when requested by the State.

40.2.7 Eligibility Verification

40.2.7.1 Eligibility Verification Overview

The Contractor must develop and operate an effective means for Medicaid providers, Contractor staff and State-designated staff to check a person's Medicaid eligibility status. Eligibility inquiries may be made by HIPAA electronic transaction, by pharmacy POS networks, via the Web portal that the Contractor must establish, through Medicaid Eligibility Verification System (MEVS) switch vendors, by an automated telephone system, to operators in telephone toll-free call centers operated by the Contractor, by fax and by other means approved by the State. Eligibility inquiries may be made individually or in a batch submission.

The Contractor must apply appropriate security in responding to eligibility inquiries, regardless of their source. The requestor must be or represent an authorized Medicaid provider at the time the inquiry is made, or be a HIPAA covered entity providing service to a Florida Medicaid recipient. The request must be for a specific recipient, and must be based on positive identification of that recipient by knowledge of the recipient's name and Medicaid ID number; the recipient's name and date of birth; or the recipient's name and social security number.

Responses will include information on recipient financial responsibility (spenddown) and recipient service limits, usage and restrictions.

The response must be in formats approved by the State. Electronic responses to HIPAA transactions must be in HIPAA formats. Responses on the Web portal must meet HIPAA standards. Responses through the automated telephone system and through toll-free call centers must meet standards approved by the State.

The Contractor must provide automated services 24 hours per day, 7 days per week. Call center services must be available to all Medicaid providers from 7:00 a.m. to 7:00 p.m. Eastern time, Monday through Friday, except on official holidays recognized and published for State employees in the State of Florida.

40.2.7.2 Eligibility Verification External Interfaces

1. HIPAA Transactions (270/271/NCPDP);
2. Medicaid Eligibility Verification System (MEVS) vendors; and

3. TCP/IP and FTP interfaces for receipt and processing of HIPAA transactions.

40.2.7.3 Eligibility Verification Inputs

1. FMMIS/DSS recipient file information;
2. HIPAA requests for eligibility verification, including MEVS inquiries;
3. Web portal inquiries;
4. Automated telephone inquiries;
5. Secure email inquiries;
6. Faxed inquiries; and
7. Call center inquiries.

40.2.7.4 Eligibility Verification Outputs

1. HIPAA transactions to convey eligibility status, including MEVS responses;
2. Web portal responses;
3. Automated telephone responses;
4. Call center responses;
5. Secure email responses; and
6. Faxed responses.

40.2.7.5 Eligibility Verification State Responsibilities

1. Determine policy for security of all modes of eligibility inquiry and response;
2. Determine policy regarding qualifications of entities to submit eligibility inquiries;
3. Set all policies and make final decisions regarding MEVS and other telecommunications contracts and operations:
   a. Advise the Contractor of any pertinent changes in the operation of MEVS when refinements or adjustments are required by federal or State authority; and
   b. Execute contracts with telecommunications vendors and notify the Contractor of each completed, renewed or terminated contract.
4. Determine policy regarding content of responses;
5. Determine policy regarding number of inquiries per call and method for handling inquiries through the telephone toll-free call center; and
6. Define content, format, frequency, and media for reports.

40.2.7.6 Eligibility Verification Contractor Responsibilities

1. Provide and operate automated services to respond to real-time electronic eligibility request transactions:
   a. Operate MEVS system, using HIPAA transactions to process inquiries from State-approved MEVS vendors;
   b. Receive and respond to TCP/IP electronic HIPAA transactions;

c. Operate automated services 24 hours per day, 7 days per week;

d. Respond to all requests within four seconds;

e. Register and test with new MEVS vendors approved by the State. Furnish technical assistance to approved providers and contracted telecommunications vendors to support their conversion to MEVS operational design requirements; and

f. Receive and respond to eligibility inquiries via a Web portal in real-time, using both a standard browser protocol and a hand-held device protocol.

2. Provide and operate automated services to respond to electronic batch eligibility transactions:

   a. Allow FTP through a Web portal;

   b. Allow tape submission;

   c. Allow other electronic batches approved by the State; and

   d. Respond to all requests within one (1) workday.

3. Operate automated telephone system to respond to eligibility inquiries using a telephone menu and response system:

   a. Automated voice response system must be available 24 hours per day, 7 days per week;

   b. System must use efficient menus. Monitor provider feedback to menus and options and make continuous improvements based on State and provider feedback; and

   c. During hours of toll-free call center operation, give providers a straightforward menu option to reach a live operator.

4. Provide and operate a toll-free call center to respond to telephone eligibility inquiries:

   a. Call center services must be available to all Medicaid providers from 7:00 a.m. to 7:00 p.m. Eastern time, Monday through Friday, except on official holidays recognized and published for State employees in the State of Florida;

   b. Answer all calls within 30 seconds; and

   c. Assure a 95% answer rate.

5. Provide eligibility verification to providers by fax or secure email;

6. Respond to all inquiries according to procedures approved by the State, regardless of method of inquiry (HIPAA, MEVS, Web, automated telephone, toll-free call center, fax):

   a. Verify the requestor identity and determine requestor's permission to receive eligibility information according to State rules;

   b. Log all transactions to provide an audit trail; and

   c. Report to the State any unusual or nonstandard communications or marketing materials from contracted vendors.

7. Monitor quality and work toward continued quality improvement:
   a. Provide information from reviewers independent of the staff performing the Eligibility Verification function;
   b. Report on quality compared to previous periods through the Performance Reporting System;
   c. Report specifically on:
      (1) Performance of computer to computer real-time and batch eligibility verification systems;
      (2) Performance of automated telephone eligibility verification systems;
      (3) Number and type of transaction generated;
      (4) Eligibility verification toll-free call center activity; and
      (5) Other items as determined by the State.
   d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and
   e. Document and implement corrective action plans when requested by the State.

40.2.8 Recipient Communications

40.2.8.1 Recipient Communications Overview

The Contractor must provide each Medicaid recipient with an identification card and notices approved by the State (See Appendix L). Notices must be dynamic and reflect choices made by the recipient or assignments made in FMMIS/DSS for enrollment in managed care, assignment of Primary Care Provider, assignment and information about special care delivery models.

The Contractor must issue replacement Medicaid ID cards or periodic replacement ID cards at the direction of the State. The Contractor must provide required HIPAA notices and other official State notices. The Contractor must translate notices into Spanish and Creole for distribution to recipients.

The Contractor must operate a Web portal and a telephone toll-free call center to receive and process recipient calls related to choice counseling calls, to request certificates of creditable coverage, HIPAA requests, and duplicate ID card requests. The Contractor must mail Explanation of Medicaid Benefits (EOMBs) to a sampling of Medicaid recipients each month, or operate an alternate means approved by the State to sample recipients for fraud and abuse control. Recipients that contact the Contractor to report suspected fraud and abuse must be immediately and properly routed to the State.

The Contractor must maintain a case log related to each recipient for use by Contractor and State staff, recording when cards were issued and replaced, when EOMBs were mailed, and recording communications the Contractor or State have with the recipient.

40.2.8.2 Recipient Communications External Interfaces

None at this time.

40.2.8.3 Recipient Communications Inputs

1. FMMIS/DSS recipient and claims files;
2. Recipient telephone calls;
3. Recipient mail and faxed requests; and
4. Recipient information received via the Web portal.

40.2.8.4 Recipient Communications Outputs

1. Identification (ID) Cards, including replacement cards;
2. Explanation Of Medicaid Benefits (EOMBs);
3. Web-based EOMBs;
4. Recipient notices; and
5. Responses to HIPAA requests, including requests for disclosure accounting.

40.2.8.5 Recipient Communications State Responsibilities

1. Determine the content, distribution and schedule for all recipient notices:
   a. Provide materials or approve content for all standard notices;
   b. Notify the Contractor of the number and sort sequence of recipient mailing labels ten (10) workdays prior to the scheduled mailing date; and
   c. Write recipient notices and deliver to the Contractor at least five (5) workdays (seven (7) workdays for the Spanish and Creole versions) prior to the scheduled mailing date.
2. Oversee, monitor and approve the design, issuance, and maintenance of Medicaid ID cards:
   a. Approve the method, schedule and packaging to be used in issuing original ID cards; and
   b. Approve procedures for issuing duplicate or replacement ID cards.
3. Approve procedures and scripts for use in processing recipient inquiries received on the Web portal or through the toll-free call center:
   a. Review and approve all HIPAA privacy request forms;
   b. Receive and process exceptional HIPAA requests that involve disclosure of Protected Health Information;
   c. Review and approve forms and procedures for processing requests for certificates of creditable coverage;
   d. Oversee and monitor the Explanation of Medicaid Benefits (EOMB) process; and
   e. Approve all security and identity verification procedures to be used on the Web portal.

4. Receive responses from mailed EOMBs and responses from the Web portal related to mailed or electronic EOMBs;
5. Enter information into the case log resulting from communications with recipients; and
6. Define content, format, frequency, and media for reports.

40.2.8.6 Recipient Communications Contractor Responsibilities

1. Produce and mail Medicaid ID cards, including any specialized cards such as MediKids, according to State specifications (refer to Appendix L for card media):
   a. Maintain the link between each recipient's card control number and their recipient ID;
   b. Package cards according to State specifications;
   c. Insert envelopes with up to four (4) Medicaid ID cards and a benefit brochure in the same envelope;
   d. Provider sufficient English and Spanish-speaking operators to respond to all calls within State-approved standards;
   e. Mail cards within one (1) workday of the time the Contractor has all the data necessary for issuing the card; and
   f. Track and provide a daily report of all returned cards, including:
      (1) Recipient's name;
      (2) Card number;
      (3) Reason for its return (moved, deceased, etc.); and
      (4) Date received by the Contractor.
2. Reissue Medicaid ID cards using procedures approved by the State:
   a. Invalidate the old Medicaid ID card, reissue and mail a replacement card within two (2) workdays when procedures for requesting reissue are complete;
   b. Accurately track the reissue; and
   c. Assign the same recipient ID to the new card.
3. Mail standard notices to recipients with the Medicaid ID card and upon any change in the recipient's Benefit Plan:
   a. Maintain content and materials as approved by the State;
   b. Mail enrollment notices, choice selection notices and notice of Benefit Plan changes within two (2) workdays;
   c. Mail annual disenrollment reminder notice as required by 42 CFR 438.10;
   d. Mail HIPAA Notice of Privacy Practices (NPP) with Medicaid ID card to new recipients;
   e. Mail the HIPAA NPP to all eligible recipients within 60 calendar days of a material revision to the notice, as directed by the State; and

f. Mail notice availability of HIPAA NPP every three (3) years to all currently eligible recipients.

4. Develop or use a COTS system to maintain a Recipient Case Log to store case notes, recipient communication history, and history of HIPAA actions (such as disclosures and disclosure reporting):
   a. Record in the Recipient Case Log the date the Medicaid ID card is mailed to the recipient, the dates of any requests for replacement ID cards, and the date such cards are actually mailed;
   b. Record a summary of all telephone communication and written correspondence with recipients;
   c. Record issuance of notices to recipients, including the HIPAA NPP; and
   d. Provide access to State staff to view and make entries into the case log.
5. Operate a Web portal for recipients to access Medicaid information:
   a. Provide security for the Web portal and identify verification procedures approved by the State;
   b. Allow recipients to use the Web portal to request a replacement Medicaid ID card;
   c. Allow recipients to view claims history and report fraud and abuse;
   d. Allow recipients to view general Medicaid information and official notices;
   e. Allow recipient to make choice selections (See Recipient Enrollment); and
   f. Allow recipients to respond to State surveys.
6. Operate a toll-free call center to receive recipient calls:
   a. Equip the toll-free call center with telephonic devices for the deaf (TDD), automatic call distribution (ACD) capable of handling the expected volume of calls, and recording capabilities;
   b. Operate the toll-free call center from 8:00 a.m. to 6:00 p.m. Eastern time, Monday through Friday (except holidays recognized for State of Florida employees);
   c. Equip the toll-free call center with telephone and report monitoring tools to assess factors such as average hold times, blocked call rates, abandonment rates, etc;
   d. Use a Language Line for additional interpretation services;
   e. Establish a State-approved caller verification process;
   f. Maintain voice mail capability and retrieve and return messages from the voice mail on the same or the following workday;
   g. Develop procedures for processing calls for State approval:
      (1) Establish procedures to efficiently process enrollment, disenrollment and plan change requests;
      (2) Establish procedures to receive and process HIPAA privacy requests and requests for accounting of Protected Health Information disclosures; and

(3) Establish procedures for issuing certificates of creditable coverage as needed in accordance with federal requirements as interpreted by the State.

h. Follow all State-approved procedures, schedules and requirements in processing recipient calls.

7. Provide the services of a Pharmacy Ombudsman's Office that will intervene on behalf of Medicaid recipients, attempt to clear rejections and drug delays, and make every effort to clear rejections immediately and get the drugs dispensed if possible and practicable. The Ombudsman function has been instituted to help avoid fair hearings on matters that could more efficiently be resolved by pharmacists on the Contractor's staff. In most cases the recipient is required to have contacted the prescriber to clear the rejection or delay prior to contacting the Ombudsman's Office. Additional information on the Ombudsman's Office can be referenced in the Medicaid Procurement Library. The Ombudsman's Office will:

   a. Provide pharmacists and pharmaceutical personnel sufficient to aggressively and effectively intervene and resolve drug disputes with prescribers and pharmacies. The Contractor may use its proposed toll-free call center facilities and tracking mechanisms, but must staff this function with appropriately credentialed employees with no other assigned duties;

   b. Maintain office hours between 8:00 a.m. and 6:00 p.m. Eastern time on all State workdays;

   c. Use a phone system able to record voice mail messages 24 hours a day and 7 days a week and will have a toll-free telephone number with adequate voicemail boxes in place to eliminate busy or no-answer responses;

   d. Maintain the ability to communicate with recipients via email or fax, and ensure email address and fax number are made available to recipients;

   e. Maintain computer links with the State's contracted Pharmacy Benefits Manager, the Department of Children and Family Services and other necessary computers/databases that the State recognizes as being useful in resolving rejection issues; and

   f. Use standard scripts provided by the State to respond to recipient calls.

8. Provide the State with recipient mailing labels at no additional cost to the State, within five (5) workdays of the request.

9. Monitor quality and work toward continued quality improvement:

   a. Provide information from reviewers independent of the staff performing the Recipient Communications function;

   b. Report on quality compared to previous periods through the Performance Reporting System;

   c. Report specifically on:

      (1) Production, issuing and reissuing of ID Cards;

      (2) Timely mailing of notices;

      (3) Performance and use of Recipient Case Log;

(4) Performance of Web portal;

(5) Call center operations; and

(6) Other items as determined by the State.

d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

e. Document and implement corrective action plans when requested by the State.

40.2.9 Recipient Maintenance

40.2.9.1 Recipient Maintenance Overview

FMMIS/DSS must maintain comprehensive information on all Medicaid recipients, including demographic information, multiple addresses, head of household and family relationship information. It must contain all eligibility information from source files, including all relevant spans and categories of eligibility.

Most recipient data fields cannot be changed in FMMIS/DSS, as they are updated automatically from source systems. However, there must be a means of posting notes to the recipient file to be used by Contractor and State staff in resolving discrepancies with the source files.

In rare cases, FMMIS/DSS must allow limited fields of data to be entered by State or Contractor staff and to override information from source files. For example, State staff may know a recipient's county of residence to be different than the source file indicates. In that case, FMMIS/DSS must allow the State staff member to post the new county of residence to a new field, which FMMIS/DSS must recognize during the Recipient Enrollment process.

The Contractor must provide mechanisms for authorized individuals to view, enter and correct certain recipient information. This functionality should be Web-based and meet the design standards of Section 40.1.3.1.

FMMIS/DSS must log all manual entries and changes to recipient files, and include the author of each. The Contractor must perform Quality Control and recipient file error sampling. All recipient files, including log files must be available to Medicaid staff authorized by the State.

40.2.9.2 Recipient Maintenance External Interfaces

None at this time.

40.2.9.3 Recipient Maintenance Inputs

1. Additions and corrections to recipient files entered by Contractor or State staff; and
2. Automated corrections made to recipient files during reconciliation processes with source files.

40.2.9.4 Recipient Maintenance Outputs

1. Corrected recipient files;

2. Logs of all additions and changes to the recipient files; and
3. Documentation indicating the source and reason for all recipient file changes.

40.2.9.5 Recipient Maintenance State Responsibilities

1. Submit requests for individual, batch or mass updates to recipient files;
2. Make additions and corrections to recipient files as allowed by State policies; and
3. Define content, format, frequency, and media for reports.

40.2.9.6 Recipient Maintenance Contractor Responsibilities

1. Maintain all FMMIS recipient files and file maintenance capabilities:
   a. Include data fields to override source data as necessary to meet FMMIS/DSS business requirements; and
   b. Include fields to log and record recipient notes.
2. Provide access to recipient file data to State and Contractor staff:
   a. Provide Web-based access that meets the design standards of Section 40.1.3.1;
   b. Provide efficient means to search for recipients by:
      (1) Recipient ID;
      (2) Social Security Number (SSN);
      (3) Medicaid ID card control number;
      (4) Medicare number;
      (5) Last name, first name, middle initial; and
      (6) Last name, first name, middle initial, and date of birth.
   c. Allow users to access all recipient related information, including recipient eligibility, demographics, family relationships, Benefit Plan assignments, choice selections, service limitations, spend-down, and all other recipient information maintained in FMMIS/DSS;
   d. Provide navigation links to view related family members;
   e. Show complete information in each field; and
   f. Log and track all user-entered changes to recipient files, including the author of the change, the date and time.
3. Provide recipient file extracts to contractors and other entities authorized by the State:
   a. Allow records to be requested, extracted and produced in real-time via a Web portal;
   b. Produce record sets that have been defined and approved in advance by the State for each recipient of data; and
   c. Provide data sets limited to a certain universe or recipients based on the particular recipient of data.

4. Monitor quality and work toward continued quality improvement:
   a. Provide information from reviewers independent of the staff performing the Recipient Maintenance function;
   b. Report on quality compared to previous periods through the Performance Reporting System;
   c. Report specifically on:
      (1) Recipient data manual overrides and corrections and reasons for change; and
      (2) Other items as determined by the State.
   d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and
   e. Document and implement corrective action plans when requested by the State.

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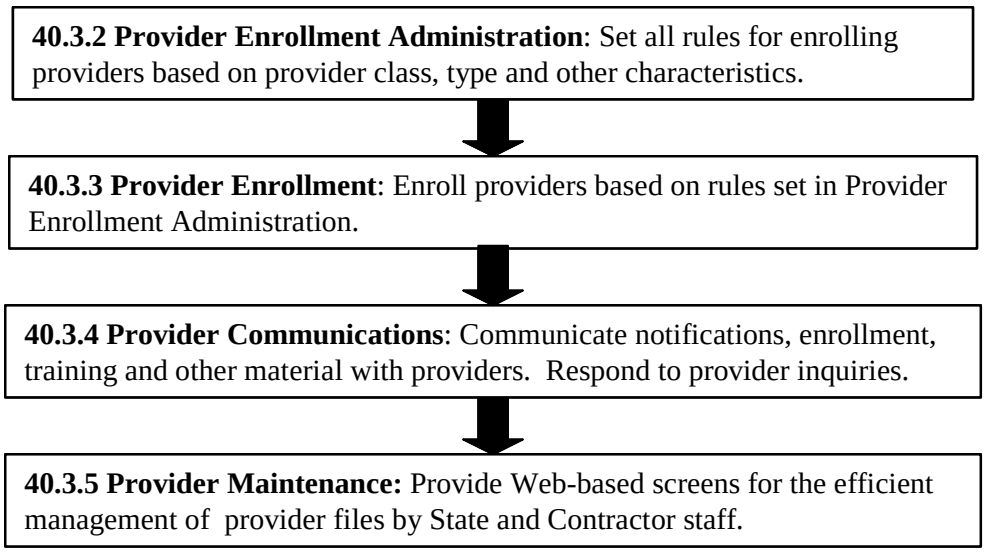
40.3 Provider Management Business Processes



40.3.1 Provider Management Introduction

40.3.1.1 Overview

The Provider Business Processes of FMMIS serve as the control point and central source of information on all Florida Medicaid providers and provider applicants. FMMIS maintains files that provide comprehensive information on each provider, billing agency, trading partner and provider group participating in the Florida Medicaid program. It carries category-of-service data, relates group and individual providers, and maintains information on accounts receivable.

FMMIS/DSS must be able to apply different rates and rate methodologies based on "provider class," provider type, provider location and provider participation in benefit plans. Provider class is an extrapolation of provider type, category of service, geographic location and other factors that specify the characteristics used to distinguish different kinds of providers in the system. The same provider may be paid at different rates depending on the recipient benefit plan or the care network under which the provider is giving service.

FMMIS/DSS must be able to properly handle institutional rates, capitation rates, discount and saving rates, fee-for-service rates based on provider class, recipient benefit plan and date range, and must be able to adjust payments for past periods of care based on audit results.

Provider information in FMMIS/DSS is critical to support claims processing, management reporting, surveillance and utilization review, and managed care operations of the program. The capability for entry, verification, and updating of provider information by online applications ensures that only qualified providers complying with program rules and regulations are reimbursed for services rendered to eligible Medicaid recipients.

40.3.1.2 Provider Management Objectives

Encourage the participation of qualified providers in the Florida Medicaid program.

Enroll providers in the Florida Medicaid program after they have met all requirements and agree to abide by the rules and regulations of the program.

Ensure that providers are qualified and eligible to render specific services under the Florida Medicaid program by screening applicants for State licensure and other State mandated credentialing requirements. This includes, but is not limited to:

- State licensure;
- Bonding;
- Background checks;
- Site visits;
- Fingerprinting;
- Medicare certification;
- Specialty board certification; and
- Other State specified criteria to be defined.

Maintain provider identifiers and information necessary to process claim and encounter records; maintain appropriate relationship to numbers assigned by the HIPAA National Provider Identifier (NPI) enumerating agency.

Provide manuals, handbooks, forms, billing guides, training and assistance to Medicaid providers. Provide special assistance to providers with billing problems and to new providers. Provider training should use Web-based technologies, but should allow for on-site training when necessary.

Provide a Web portal for providers to access information pertinent to their participation in the Florida Medicaid program including:

- Enrollment application submission and processing;
- Provider training;
- Provider handbook access;
- Provider billing instructions;
- Provider bulletins;
- Recipient eligibility verification;
- Claims submission and correction;
- Fraud and abuse reporting;
- Remittance vouchers;
- Payment status;
- Claim status; and
- Suggestions to resolve billing problems.

40.3.2 Provider Enrollment Administration

40.3.2.1 Provider Enrollment Administration Overview

Provider Enrollment Administration encompasses the file maintenance activities involved in setting up the rules and classifications for enrollment of Medicaid providers. The business process of enrolling providers should be automated, using a Rules Engine and a workflow management engine to make the process more

efficient. Provider Enrollment Administration is a new concept for this contract, based on the State's initial steps toward MITA compliance.

40.3.2.2 Provider Enrollment Administration External Interfaces

None at this time.

40.3.2.3 Provider Enrollment Administration Inputs

Data entered into the Rules Engine by Contractor or State staff.

40.3.2.4 Provider Enrollment Administration Outputs

FMMIS/DSS provider file structures, processing rules, forms and work flow controls necessary to manage the provider enrollment process according to State-defined criteria.

40.3.2.5 Provider Enrollment Administration State Responsibilities

1. Participate with the Contractor in the design and development of FMMIS/DSS functions related to Provider Enrollment Administration;
2. Provide initial data for system operation, including the list of provider classes, enrollment criteria for each, and enrollment steps and process flow for each;
3. Enter data into the Rules Engine to change enrollment criteria, enrollment steps or workflow; or provide information to the Contractor for the Contractor to enter changes into the Rules Engine; and
4. Initiate CSRs to the Contractor for changes in the design and operation of the Provider Enrollment Administration Process.

40.3.2.6 Provider Enrollment Administration Contractor Responsibilities

1. Design, develop and implement a Provider Enrollment Administration System as described in this section:
    a. Provide maintenance capabilities to Contractor and State staff to set new provider classes, modify requirements for each provider class, set and modify enrollment steps, set and modify provider enrollment workflow;
    b. Use a Rules Engine and workflow management system to govern the rules and processes for provider enrollment; and
    c. Process information supplied by the State or trouble-shoot data entered by the State to make sure the Rules Engine and workflow management process operate properly.
2. Classify providers in the Florida Medicaid program using user-defined credentialing and enrollment criteria based on:
    a. Provider type;
    b. Provider class;
    c. Specialties;
    d. Locations;
    e. Ownership;

f. Group affiliations; and

g. Other criteria as defined by the State;

3. Provide an automated workflow management system and process. The process steps must be easily modifiable by the State or Contractor as processing rules change. These process steps may include:

   a. NPI verification;

   b. DOH licensure;

   c. Credentialing;

   d. Interface with AHCA's Health Quality Assurance;

   e. Fingerprints;

   f. Background checks;

   g. Ownership recording and verification;

   h. HMO or other MCO contracting;

   i. Site visits;

   j. Notarized forms;

   k. Desk reviews; and

   l. Other criteria as defined by the State.

4. Analyze, develop and implement a cohesive method to process and use the National Provider Identifier (NPI) in adherence to the HIPAA NPI rule:

   a. Receive direction from the State and the incumbent fiscal agent during the Design and Development Phase to understand the State's strategy of utilizing the NPI;

   b. Prepare a detailed plan for State approval for implementing NPI in FMMIS/DSS. Take into consideration and discuss in the detailed plan:

      (1) Providers that are not eligible for NPI enumeration;

      (2) Possible use of HIPAA taxonomy for fraud and abuse control;

      (3) Use of NPI as referring provider, treating provider, prescribing provider, billing provider or attending practitioner;

      (4) Data conversion of claims, encounter data, and Service Authorizations from prior periods that did not utilize the NPI;

      (5) Reenrollment or recertification of providers based on NPI;

      (6) Credentialing providers based on NPI;

      (7) Providers not enrolled in Florida Medicaid but providing services such as providing services in MCOs, prescribing drugs, referrals, or other attending procedures;

      (8) Educating providers on the use of NPI for billing, claim inquiry, electronic and paper transactions, referrals, prescriptions and all other relevant topics; and

(9) Changes in State policies or procedures that may need to occur to support NPI.

c. Implement FMMIS/DSS designs for the NPI based on the detailed plan approved by the State in accordance with federal guidelines; and

d. Prepare provider education materials and include NPI as a major subject for provider training in advance of Implementation.

5. Notify the State of any significant failure in FMMIS/DSS to properly carry out the business functions of Provider Enrollment Administration within one (1) workday;

6. Study and analyze all relevant programs and operating procedures in the current FMMIS as it is being operated during the period of Design and Development Phase, including all relevant Customer Service Requests and contract amendments:

   a. Formulate the initial business rules for this business process based on the current MMIS operations;

   b. Submit the proposed rules to the State for approval;

   c. Enter those rules approved by the State into the Rules Engine;

   d. Test the rules to assure they process as expected, compared to current FMMIS operations; and

   e. During the Readiness Testing Period, demonstrate the accuracy of rules application by proving the comparison to current fiscal agent operations; document and explain any differences to the satisfaction of the State; and

7. Monitor quality and work toward continued quality improvement:

   a. Provide information from reviewers independent of the staff performing the Provider Enrollment function;

   b. Report on quality compared to previous periods through the Performance Reporting System;

   c. Report specifically on:

      (1) Number of applications received;

      (2) Number at each step in the process;

      (3) Number enrolled by class or type;

      (4) Performance of work flow engine; and

      (5) Other items as determined by the State.

   d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

   e. Document and implement corrective action plans when requested by the State.

40.3.3 Provider Enrollment Processing

40.3.3.1 Provider Enrollment Processing Overview

The Provider Enrollment/Re-enrollment function is responsible for receiving and processing applications for provider participation; receiving and processing provider agreements; determining provider eligibility; verifying licensure; determining proper credentials, including requesting and processing information related to criminal background checks and handling of fingerprint data; bonding, address verification, performing provider site visits, and verifying Medicare and other certifications.

The Contractor must carry out this function based on rules itemized by the State using FMMIS/DSS functions governed by the Provider Enrollment Administration business function Rules Engine. The Contractor must make efficient tools available to providers and the State for this purpose, including a Web portal.

The Contractor must maintain the record of all relevant provider information, including provider enumerations (NPI, Medicare, etc.) owners, affiliations, billing agents, locations, specialties, addresses, contacts, and email address.

The Contractor must enroll out-of-state providers under rules set by the State as necessary for the operation of the Medicaid program.

40.3.3.2 Provider Enrollment Processing External Interfaces

1. Professional License Interface: The Contractor must develop or enhance interfaces with the Florida Department of Health and the Agency for Healthcare Administration licensure files to:
    a. Automatically verify licenses required for provider participation under a schedule determined by the State; and
    b. When possible, notify providers of expiring licenses by email and with further automated follow up. Until such an interface can be implemented, the Contractor must use batch files and manual processes to accomplish this purpose upon provider enrollment application and at least quarterly.
2. Laboratory File Interface: FMMIS/DSS interfaces with the AHCA laboratory file, which contains CLIA certified providers and their classifications. The interface must load and verify the CLIA provider number, status, and specialties for which a provider is approved and can deny claims based upon CLIA specialties and subspecialties found on the OSCAR file;
3. Background Check Interface: The Contractor will provide and receive interface files in formats designated by the State;
4. National Provider Identifier (NPI) Interface: The Contractor must interface with enumerator agency to verify the NPI of provider applicants. Details on this interface are not yet available;
5. Secretary of State Corporations Interface: When possible, the Contractor must interface with the Florida Secretary of State databases to verify ownership information;
6. Establish and provide data exchange and data validation through electronic interfaces with other entities, including but not limited to the following. Interface criteria will be defined during the Design and Development Phase of the contract:

a. Department of Health (DOH);
b. AHCA – background check;
c. Department of Children and Families (DCF);
d. Division of Corporations for ownership changes;
e. Florida Department of Law Enforcement (FDLE);
f. Agency for Persons with Disabilities (APD);
g. Department of Elder Affairs (DOEA);
h. Drug Enforcement Agency (DEA);
i. Oscar (CLIA information);
j. National Practitioner Database (NPDB);
k. Provider credentialing agencies;
l. Health Quality Assurance (HQA);
m. Department of Financial Services (DFS);
n. AHCA Home Medical Equipment (HME) unit;
o. Office of Insurance Information (OIR); and
p. Bureau of Vital Statistics.

40.3.3.3 Provider Enrollment Processing Inputs

1. Enrollment applications submitted by providers via the Web portal, via secure email and via the mail;
2. Criminal background check information supplied by the State of Florida through automated interfaces and manual processes;
3. Supporting documentation supplied by the providers and credentialing agencies; and
4. Credentialing and validation information supplied through the Provider Enrollment Processing Interfaces.

40.3.3.4 Provider Enrollment Processing Outputs

1. Electronic records of all applicant information, including images of all paper documents received as part of the enrollment process;
2. Enrollment notifications to the provider as determined by the Provider Enrollment Administration rules; and
3. FMMIS/DSS provider-related files with all information necessary to administer provider enrollment, claims processing, health quality, program monitoring and reporting.

40.3.3.5 Provider Enrollment Processing State Responsibilities

1. Establish policy and make all administrative decisions concerning provider eligibility and enrollment in Florida Medicaid:

a. Approve all forms (electronic and paper) including but not limited to those used for ECS, EFT, provider billing agent agreements, ARNP and Physician Assistant collaboration forms, and other enrollment processing forms as directed by the State;

b. Approve all procedures and systems used by the Contractor for provider enrollment;

c. Draft standard provider agreements, enrollment applications, application instructions, criminal history check brochures, and related enrollment policies and documents; and

d. Decide when to renew provider agreements and re-enroll providers. Prepare a schedule for this process.

2. Monitor the provider enrollment process, including sampling non-institutional enrollments and both institutional and non-institutional file maintenance; and

3. Establish and maintain effective relations with the provider community and provider associations.

40.3.3.6 Provider Enrollment Processing Contractor Responsibilities

1. Establish a Provider Enrollment Unit to support provider enrollment/re-enrollment and credentialing functions as follows:

   a. Create operating procedures for the Provider Enrollment Unit for State approval;

   b. Allow the State or the Contractor to enter enrollment rules into the Provider Enrollment Administration Rules Engine; and

   c. Maintain systems and procedures that allow enrollment of test providers.

2. Enroll providers in the Florida Medicaid program using the rules, steps, and work flow process approved by the State. Providers must be fully enrolled and activated within two (2) workdays of completion of all requirements set by the State:

   a. Print current and approved provider enrollment packages and mail them within two (2) workdays of requests from potential providers. The Contractor must have the applications available at all times and keep the application enrollment package up-to-date. The Contractor must provide the requested numbers of blank applications within five (5) workdays of the request from any State office. An example of a provider's enrollment package is included in the Medicaid Procurement Library;

   b. Image all provider enrollment/re-enrollment applications and supporting documentation within two (2) workdays of completion of all enrollment requirements. Imaging of current hard copy documents from provider file is required at the time of reenrollment;

   c. Enroll out-of-state providers according to the State policy. Notify out-of-state providers of their provider number and basic billing requirements;

   d. Maintain signed provider contracts for reimbursement of claims via electronic funds transfer (EFT). EFT is mandatory for all providers, with limited exceptions as defined by the State; and

e. Approve and process enrollment applications for institutional facilities (nursing facilities, ICF/DD, hospitals, swing bed facilities, ambulatory surgery centers, hospices, home health agencies, community mental health centers, and State mental health hospitals) and others as determined by Provider Enrollment Administration rules.

3. Maintain a Web portal for provider applicants, State and Contractor staff to use to follow the provider enrollment process as set by the rules of Provider Enrollment Administration. The portal must also include information such as downloadable enrollment forms, claims and special billing forms, upcoming training announcements, field representatives' names and phone numbers, recent RV banner messages, a hot link to the Agency Web site, and other material that would be useful to providers as approved by the State. The online application has to be consistent with the paper enrollment form and both maintained in synchronous fashion;

4. Document enrollments and send notice of enrollment and provider manuals to enrolled providers within five (5) workdays of completion of enrollment:

   a. Provide a mechanism, i.e. email or other mechanism, to notify a provider when the application has been approved or denied. If denied, the reason for the denial must accompany the notification;

   b. Mail a CD with the provider handbooks to new providers with their enrollment notifications. The first CD mailed to a provider is at no charge; and

   c. Provide additional copies of the handbook CD upon provider request. Providers may be charged $10.00 for each additional CD.

5. At the direction of the State, conduct the renewal of provider agreements for all non-institutional providers every three (3) years. Re-enroll non-institutional providers by provider type, allowing each group a minimum of sixty (60) calendar days to return applications and sixty (60) calendar days to complete processing by the Contractor. Provider types will be selected by the State to allow full re-enrollment to occur over a three (3) year period;

6. At the direction of the State, conduct the renewal of provider agreements for institutional providers;

7. Maintain provider files:

   a. Organize and maintain all paper provider files in provider number order. The Contractor is required to keep all provider files current, and to file all items within two (2) workdays;

   b. Maintain electronic provider files in a manner that allows State and Contractor staff easy navigation directly to source documents, including images of all paper enrollment files; and

   c. Maintain serialized and notarized change of address information as specified in rules of Provider Enrollment Administration.

8. Monitor quality and work toward continued quality improvement:

   a. Provide information from reviewers independent of the staff performing the provider enrollment function;

b. Report on quality compared to previous periods through the Performance Reporting System;

c. Report specifically on:

(1) Number of providers enrolled and re-enrolled;

(2) Compliance with enrollment workflow timeline requirements;

(3) Provider file audit activity; and

(4) Other items as determined by the State.

d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

e. Document and implement corrective action plans when requested by the State.

40.3.4 Provider Communications

40.3.4.1 Provider Communications Overview

The Contractor must maintain efficient communications with provider applicants and providers enrolled in the Medicaid program, including notifications of enrollment status, training on Medicaid's policies and procedures and to answer inquires received from providers. Provider inquiries can be received via email, written correspondence, telephone calls, field visits to provider's offices and from professional provider associations either directly to the Fiscal Agent or through the State Medicaid office.

40.3.4.2 Provider Communications External Interfaces

None at this time.

40.3.4.3 Provider Communications Inputs

1. Written or verbal (via telephone) issues or concerns by provider applicants and Medicaid providers;
2. Policies communicated by the State to the Contractor;
3. Bulletin and notice information supplied by the State to the Contractor; and
4. FMMIS/DSS information regarding enrollment status, submitted claims, fee schedules, recipient eligibility, recipient caps.

40.3.4.4 Provider Communications Outputs

1. Communications to providers on the telephone, in person, in writing, through email, and posted on the Web portal; and
2. Provider manuals, billing guides, forms, and other printed and electronically published materials.

40.3.4.5 Provider Communications State Responsibilities

1. Provide information and materials to the Contractor for creation of handbooks, notices, bulletins and other published materials;
2. Approve final versions of all notices, bulletins, handbooks, forms and other printed and electronic published materials;
3. Approve all systems, procedures, methods, scripts, and staffing plans to be used for provider toll-free call center operations;
4. Control handbook content, format, schedule of production and release of material; and
5. Monitor toll-free call center operations through use of the Performance Reporting System, audits, reports, sampling, and on-site inspection at any time.

40.3.4.6 Provider Communications Contractor Responsibilities

1. Maintain and staff a Provider Call Center that includes toll free telephone lines:
   a. Staff operators must be available to answer calls from 7:00 a.m. to 6:00 p.m., Eastern time, Monday through Friday;
   b. Install, operate, and maintain the necessary software, Automated Voice Response System (AVRS) equipment, and telecommunication lines to provide toll-free access for providers twenty-four (24) hours a day, seven (7) days a week, except for agreed upon down time for maintenance to support inquiries into provider payments. Information provided by the AVRS will be determined by the State;
   c. Automatically answer provider calls at all times. Develop or use a COTS Call Center Management system that provides for answering calls in sequence, recording and printing statistics, and indicating calls that have been placed on hold for a specific time limit;
   d. Provide reports generated from this system to the State at least monthly. Assure that the system automatically notifies the State when performance is outside the tolerance limits that will be established in the Performance Reporting System;
   e. Add and maintain a sufficient number of telephone lines and staff so that at least ninety percent (90%) of incoming calls per day are answered and handled;
   f. Return all calls within two (2) workdays of receipt. The State will monitor the Contractor's performance and blockage rate by calculating monthly averages. Submit reports from the voice telecommunications vendor at the State’s request to allow this calculation to be made;
   g. Assure that a caller will not be placed on hold for more than one minute without response by a human operator to the caller's inquiry;
   h. Provide one (1) toll free line for use by the State provider relations staff to dial into FMMIS/DSS and retrieve online information while working with individual providers on provider issues or complaints. The Contractor will maintain a list of persons authorized to use this line and will report the usage and any attempted violations of this line to the joint security team;

i. Respond to all verbal provider inquiries on recipient eligibility, provider status, claim status, billing procedures, and remittance vouchers immediately, if possible. If immediate verbal responses are not possible, written responses to verbal inquiries will be made within five (5) workdays of the date of the call. The State will approve all form letters in writing before they are put in use;

j. Maintain and review statistics showing the reasons for calls, and initiate enhancements to reduce the number, duration, and manual processing time for calls through better automation, and/or training;

k. Provide dedicated (individual) phone lines to all Contractor staff with telephone call message mailbox capability. The Contractor staff shall review and respond to all phone messages within two (2) workdays. Log messages with the date of the message and date the call is returned, including the provider number, provider name, telephone number and contact person;

l. Restrict telephone inquiries to Medicaid providers whether active or terminated, including billing agents and State staff. Information provided to terminated providers will be limited to the period of their valid enrollment and re-enrollment information;

m. Maintain bilingual (Spanish and English) capabilities on the provider communication staff as necessary to meet the above requirements; and

n. Provide the capability to monitor or record operator calls for quality assurance purposes.

2. Perform provider and staff training:

a. Provide all staff required in section 50.2, including trainers and field representatives;

b. Train Contractor provider communications staff in billing procedures, current Florida Medicaid billing policies, and telephone etiquette. Provide for periodic training of telephone operators. All operators must complete a State approved customer relations training program on a periodic basis as mandated by the State;

c. Develop and update professional training materials, to be approved by the State, for use in area provider training seminars that are conducted by area Medicaid staff;

d. Use field representatives to provide training, claims resolution, and assistance to Medicaid providers. These staff must be assigned to locations designated by the State. Any changes in the assigned location of the provider field representatives must be approved by the State. The provider field representatives serving predominately Spanish-speaking provider groups must be bilingual (English and Spanish). Specifically, at a minimum, the provider field representatives must:

(1) Attend Medicaid headquarters' in-service training and participate in statewide meetings with Medicaid headquarters and area staff to determine the subjects on which providers need to be trained and the types of training materials that need to be developed;

(2) Present training seminars to providers requesting such training in conjunction with the area Medicaid staff;

(3) Provide special training related to policy changes affecting specific providers prior to implementation of new policies and services;

(4) Offer training to new providers and the billing clerks who will be submitting claims for the new provider; and

(5) Conduct on-site visits to providers for claims resolution assistance.

e. Track and report all provider on-site training and subsequent visits;

f. Develop and update professional training materials for use by the Contractor's field representatives on-site training at providers' offices;

g. Develop all training materials for seminar and Web-based delivery, subject to State approval of course structure and contents and provide the State with hard and electronic copies of all the training materials;

h. For newly enrolled providers, provide for the initial training to be performed online with follow-up on-site training by a provider representative. Provide an online tutorial that providers can access at their convenience. Track and report when newly enrolled providers complete the initial training tutorial;

i. Conduct in-service training for the Contractor's provider services team; and

j. Ensure that all training materials are approved by the State.

3. Coordinate and produce provider handbooks, publications and other provider communications:

a. Provide notice of enrollment approval or denial to providers and provide handbooks based on materials and information supplied by the State as required in Section 40.3.3.6;

b. Develop or use COTS products, such as desktop publishing software, to systematically produce professional quality handbooks on CDs. Products must be accessible to State staff and be able to produce handbook material in State-approved formats in an automated process;

c. Allow sections of the handbooks to be stored in data files for re-use and incorporation into several handbooks;

d. Allow State staff to update materials in handbook data files;

e. Prepare and distribute provider handbook material on CD;

f. Obtain at least three (3) bids for print and distribution unless otherwise directed by the State, allowing five (5) workdays for bids;

g. Select lowest bid and print and publish hard copy within fifteen (15) workdays of receiving the bids:

(1) Provider Bulletins when directed by the State;

(2) The quarterly Medicaid bulletin;

(3) Policy material;

(4) Provider notices; and

(5) Other publications.

h. Maintain documentation of bids and selection for State review before payment.

i. Publish final communications to the Web portal within three (3) workdays as directed by the State;

j. Maintain all publications in electronic files and make available on the Web portal all provider bulletins, manuals, notices and other publications;

k. Maintain version history for use by State legal staff of all bulletins, notices, forms and handbooks;

l. Maintain updated State letterhead and electronic signatures of State officials who sign computer generated letters;

m. Write and submit appropriate articles to the State for the quarterly Medicaid Bulletin;

n. Provide to the State provider mailing labels within five (5) workdays of request;

o. Produce and mail computer-generated approval and change letters and group mailings. Obtain written approval of all written communication to multiple providers prior to distribution of the documents; and

p. Provide special marketing mail packages and handling services for Medicaid contract managed care plans. Reimbursement for such services will be negotiated in good faith between the Contractor and the managed care plan and approved by the State. The State will approve the content for each of these special mailings;

4. Print and maintain an inventory of claims and forms:

   a. Provide a preprinted, self-mailing order form for providers to request and receive all Contractor-supplied forms;

   b. Send claim forms to providers within five (5) calendar days of the receipt of request from providers; and

   c. Maintain ECS, EFT, provider billing agent agreements, Physician Assistant and ARNP collaboration agreement forms as supplied by the State.

5. Create and maintain a Web portal to provide provider billing information:

   a. Provide question-specific search capabilities on the Web portal, i.e. what services does Florida Medicaid cover and the coverage limitations;

   b. Provide an alert message at the time of sign-on to the Web portal that alerts providers and other interested parties of important messages or policy changes relating to the Medicaid program, including a searchable archive of previously posted messages;

   c. Provide the ability for providers to order claims forms;

   d. Make forms available through the Web portal (such as sterilization forms);

   e. Allow providers the ability to complete the forms online and submit to the Contractor. Associate completed forms to the appropriate recipient and service claim;

   f. Allow online responses to Agency provider surveys;

g. Allow providers to request file corrections online. Record corrections only as allowed by State-approved procedures; and

h. Publish on the Web portal State approved information and tables listing procedure codes, diagnosis codes, service limits, and reimbursement amounts.

6. Provide the ability to send providers email with alert messages by provider class, provider type, or other groupings of providers;

7. Provide support for the State's provider surveys, including printing survey forms, selecting providers, distributing surveys, and assisting in the analysis of survey results and summarizing results;

8. Generate and distribute provider 1099 forms and 1099 reports:

   a. Calculate 1099s based on Federal Employee Identification Number (FEIN) or Social Security Number (tax ID) and accumulate all payments to the same tax ID on a single 1099;

   b. Respond to all provider inquiries regarding 1099s including incorrect FEINs;

   c. Resolve all 1099 issues regarding correct reporting of tax information based on the federal 1099 policies;

   d. Research and resolve problems identified by providers with 1099s;

   e. Issue amended 1099s if research indicates inaccuracies whether created by the State or the Contractor;

   f. Resolve 1099 issues required by the IRS to avoid penalties;

   g. Assume all responsibility and accountability for any damages caused by inaccurate information under the Contractor's responsibility; and

   h. Balance data to be used in 1099 generation monthly, and provide a monthly report demonstrating that 1099 production is in balance;

9. Monitor quality and work toward continued quality improvement:

   a. Provide information from reviewers independent of the staff performing the Provider Communications function;

   b. Report on quality compared to previous periods through the Performance Reporting System;

   c. Report specifically on:

      (1) Number of telephone calls received and lost;

      (2) Time to return telephone calls;

      (3) Caller "on-hold" average time;

      (4) Number of providers trained and in receipt of printed materials; and

      (5) Other items as determined by the State.

   d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

e. Document and implement corrective action plans when requested by the State.

40.3.5 Provider Maintenance

40.3.5.1 Provider Maintenance Overview

FMMIS/DSS must maintain comprehensive information on all provider applicants and Florida Medicaid providers, including billing agents, POS switch vendors, and any other trading partners. It must contain historical rates and type of service information for providers, allow for the relationship of providers, provider groups, and persons with ownership or management interest to be recorded and tracked. It must also carry accounts receivable data and have the capability to place restrictions on provider claims payments.

Provider files are used for verification of provider eligibility during claims processing and to support administrative and surveillance and utilization review reporting.

The Contractor must exert special control on provider address changes, security of the provider's access to the Web portal and other FMMIS/DSS information, and changes that impact provider payments.

40.3.5.2 Provider Maintenance External Interfaces

None at this time. There will be a future requirement to interface with the National Provider System (NPS) to obtain or correct National Provider Identifier (NPI) information.

40.3.5.3 Provider Maintenance Inputs

1. Additions, updates and corrections to provider files received from providers, processed in accordance with State policies and rules or entered by authorized State staff; and
2. Requests from the State to process batch or mass updates to provider files.

40.3.5.4 Provider Maintenance Outputs

1. Corrected provider files;
2. Logs of all additions and changes to the provider files; and
3. Documentation indicating the source and reason for all provider file changes.

40.3.5.5 Provider Maintenance State Responsibilities

1. Submit requests for individual, batch or mass updates to provider files; and
2. Make additions and corrections to provider files as allowed by State policies.

40.3.5.6 Provider Maintenance Contractor Responsibilities

1. Provide the maintenance functions required to support the Provider Maintenance capability:
   a. Provide data entry fields to identify multiple practice locations of a single provider to allow remittances to be sent to provider-designated location, subject to rules; and

b. Provide data entry fields within FMMIS/DSS to record all information necessary to manage FMMIS/DSS business processes described in this RFP, including information on HMO and Managed Care providers, billing agents, HIPAA-compliant clearinghouses, POS switch vendors, and all trading partners.

2. Make all provider file updates according to systematic processing rules or procedures authorized by the State:

   a. Update all relevant provider files with State-approved individual, batch or mass updates; individual updates must be made within one (1) workday of receipt and other updates must be made within the time frame directed by the State; maintain documentation logs to show the timeliness of all updates;

   b. Maintain a provider numbering system with unique numbers and appropriate correlations to National Provider Identifier (NPI), Universal Provider Identifier (UPIN), and other provider identifiers from other systems necessary for the proper editing and processing of claims;

   c. Maintain and automatically enforce consistent provider naming conventions to differentiate between first names, last names, and business or corporate names, and to allow flexible searches based on the provider name;

   d. Regulate and monitor the provider files to prevent assigning multiple provider numbers to a single provider;

   e. Provide Web-based, online inquiry capability by provider name, provider number, provider type, provider county, provider type by county, group affiliation, and license number. Provide the capability to allow an authorized user to query and report on any and all fields, including but not limited to pending applications, based on provider type, provider specialty, full name, partial name, address, d/b/a information;

   f. Maintain provider associate information, such as owner(s) name(s), phone numbers, email address, EFT signer, financial custodian, etc. Fields must have related begin, end, and update dates;

   g. Provide data entry fields to allow providers to have different electronic submission status; ensure that providers in the process of testing the submission or receipt of electronic files, or who are otherwise in test mode, cannot erroneously submit claims to production;

   h. Maintain capability to identify providers authorized for electronic claims submission (ECS), point-of-service transactions, electronic funds transfer (EFT), and electronic remittance voucher; and

   i. Allow outside entity such as the contracted PRO access to FMMIS/DSS to enter review findings such as a pass/fail indicator.

3. Provide for the tracking and logging of all maintenance and inquiry activities:

   a. Maintain a Provider Log of notes for various purposes, including call-center calls from the provider, other communications with the provider, notices given, provider comments, and field representative visits. State staff must be able to enter information into the log. FMMIS/DSS must log all entries and changes, and include the author of each. The Contractor must perform

Quality Control and provider file error sampling. All provider files, including log files must be available to Medicaid staff authorized by the State; and

b. Ensure that online transaction logs are maintained on all provider related files with the dates, time, and fields changed. This audit trail must include date/time stamp, person performing the action, and why the action was performed. Transaction logs must be indexed for efficient searches.

4. Monitor quality and work toward continued quality improvement:

   a. Provide information from reviewers independent of the staff performing the Provider Maintenance function;

   b. Report on quality compared to previous periods through the Performance Reporting System;

   c. Report specifically on:

      (1) Number of providers entered or updated;

      (2) Timeliness of provider updates; and

      (3) Other items as determined by the State.

   d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

   e. Document and implement corrective action plans when requested by the State.

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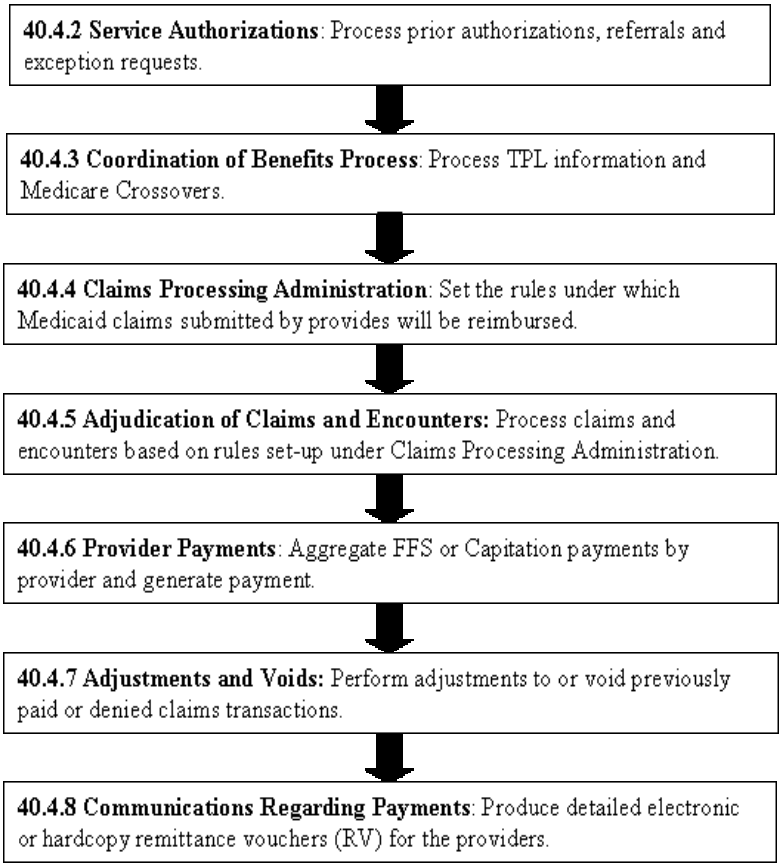
40.4 Payment Management Business Function



40.4.1 Introduction

40.4.1.1 Payment Management Overview

In the Payment Management business function, the Contractor must maintain FMMIS/DSS rules and systems to accurately capture and adjudicate all submitted claims (paper and electronic) and to assure timely, accurate, and appropriate payment of claims for services based on State approved guidelines and procedures. The Contractor must develop or use a COTS package to record claims processing rules entered into the system or otherwise set by the State. FMMIS/DSS must capture, control, and process claims data from the time of initial receipt (on hard copy or electronic media) through the final disposition, payment, and archiving according to those rules.

The Contractor must also receive and process encounter data. Adjudication rules for encounter data will be different from claims, but will require application of edits and comparative pricing.

40.4.1.2 Payment Management State Objectives

1. Ensure that claims and encounter data received are input into FMMIS/DSS at the earliest possible time and in an accurate manner;

2. Establish hierarchical rules for the processing of claims using a Rules Engine that can be modified by or at the direction of the State;
3. Establish control over all transactions during their entire processing cycle:
4. Apply all edits and audits specified by the rules in force when each claim is processed. Rules in force may be different based on the date of claim processing and the date of service reported on the claim. Rules in force may require manual intervention or manual pricing as part of the process;
5. Verify that all providers submitting electronic input are properly enrolled when submitting electronic claims. Pay no claim if the provider was not properly enrolled at the time of service;
6. Ensure that all recipients are eligible for the type of service at the time the service was rendered; and
7. Ensure that reimbursements to providers are made timely and correctly;
8. Maintain all processed data necessary to satisfy State and federal requirements and the needs of other business functions, at a minimum this must include accurate and complete registers and audit trails of all processing for seven (7) years from date of processing;
9. Process various types of requests to authorize services and medications;
10. Process claims adjustments;
11. Process claims from out-of-state providers;
12. Process exceptional claims;
13. Create a computer file of TPL information from adjudicated claims to support recoveries from private carriers and other third party insurers;
14. Uniquely identify and locate any provider claims in accordance with federal requirements;
15. Provide a prompt response to all inquiries regarding status of any claim; and
16. Establish and maintain the capability to track and compare encounter data from MCOs and other service networks to each other, to fee-for-service providers and to national norms to set policy and rates, to analyze and budget costs, and to better determine the quality of care.

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40.4.2 Service Authorization Business Processes

40.4.2.1 Overview

To control costs and assure appropriate care, Florida Medicaid often requires that medical services for a recipient be reviewed before or after delivery and specifically be approved or denied. This review process is performed by Contractor staff, staff from Medicaid State headquarters, staff from Medicaid Area Offices, waiver program staff members, Primary Care Providers in MediPass and other service networks, and by Peer Review Organizations (PRO) and additional State contractors. FMMIS/DSS must include a unified approach to these Service Authorizations.

Some services are authorized in a plan of care that allows a certain number of procedures in a specified time frame. Some services are authorized to be performed by a specific provider, while others may be performed by any qualified provider. Some services are very restrictive, and may only be done within a certain date range, or in conjunction with another procedure. Some services may be provided up to a certain dollar limit for a recipient within a time frame while some services may be provided only in specific geographic areas. Service authorizations include referrals to a specialist by Primary Care Providers. All Service Authorizations must be assigned a unique authorization number, including MediPass Service Authorizations.

Florida allows consumer-directed care for some recipients, limiting certain medical expenses to a maximum expenditure as authorized by the recipient. This will probably be expanded as a part of Medicaid Reform. The Service Authorization process combined with the Benefit Plan structure must accommodate and control these expenditures.

Some services may be allowed only if the recipient has received preventive care and immunizations.

Florida operates a gatekeeper system called MediPass, in which recipients are assigned to selected Primary Care Providers (PCPs). The PCPS are paid a monthly case management fee. Part of their responsibility is to control access to hospital and specialist care to assure appropriate care is given. The Service Authorization business process must provide simple and accessible ways for PCPs to authorize care and for other care-givers to obtain proof of Service Authorization. The process must be accurate and reliable, must utilize unique authorization numbers and must facilitate reporting to measure and monitor effectiveness of the MediPass program.

The Contractor must use a Rules Engine to record requirements for Service Authorizations, combined with a workflow management system to control the steps for receiving, processing, approving and denying Service Authorization requests (the “Service Authorization System”).

40.4.2.2 Service Authorization External Interfaces

1. HIPAA electronic transactions;
2. POS processing system;
3. Area Medicaid offices systems;
4. Service Authorization contractors’ systems;
5. Automated Voice Response System (AVRS); and

6. Web portal.

40.4.2.3 Service Authorization Inputs

1. Service Authorization rules supplied by State staff;
2. Requests for Service Authorizations (X12 278 Requests for Authorization and Services Review);
3. FMMIS/DSS recipient, claims and provider data;
4. Service Authorization approvals and denials from State headquarters staff;
5. Service Authorization approvals and denials from contractors;
6. Service Authorization approvals and denials from Area Offices;
7. Referral and Service Authorizations from MediPass and other providers; and
8. Developmentally Disabled and other service plans or authorized plans of care.

40.4.2.4 Service Authorization Outputs

1. Responses to Service Authorization Requests (X12 278 Response to an Authorization and Services Review Request);
2. Letters to providers and recipients indicating approved, denied, or cancelled Service Authorizations; and
3. Service Authorization records to be used in claims processing and reporting.

40.4.2.5 Service Authorization State Responsibilities

1. Post to the Rules Engine or provide to the Contractor the drug codes, procedure codes, diagnosis codes, and categories of services requiring Service Authorization;
2. Define the workflow for adjudicating Service Authorization requests/amendments;
3. Review and approve criteria used by the State and the Contractor's clinical consultants and analysts to evaluate Service Authorization requests/amendments and materials submitted;
4. Review and approve Service Authorization restrictions, including system edit and audit checks;
5. Approve the format and content of all Service Authorization forms and related material;
6. Approve the content, frequency and number of all Service Authorization communications to providers and recipients;
7. Provide Service Authorization purging and archiving criteria;
8. Define the desired content, format, frequency, and media for reports; and
9. Initiate and interpret all policy and make administrative decisions regarding exceptions to drug coverage and limitations.

40.4.2.6 Service Authorization Contractor Responsibilities

1. Design, develop and install or integrate an existing COTS automated Service Authorization System:
   a. Use an automated workflow system for routing, review, adjudicating, tracking, and updating of Service Authorization requests and amendments. Use this Service Authorization workflow management engine to route all electronic Service Authorization requests to the appropriate person immediately upon receipt;
   b. Image all service request forms and make available for viewing in FMMIS/DSS. Imaged files must be easily accessible by hypertext link from view of recipient, claims or Service Authorization screens;
   c. Accept Web based, direct online entry, batch entry, paper, fax, and telephone Service Authorization requests, or other methods as directed by the State. Make full use of HIPAA 278 and HIPAA 275 transactions when available;
   d. Assign a unique identification number to each Service Authorization including MediPass authorization within one (1) workday or less of the request as directed by the State;
   e. Provide automated process to link hard copy Service Authorization attachments received by fax or in the mail, such as x-rays and dental models, with the corresponding Service Authorizations that have been submitted electronically; and
   f. Provide a mechanism to receive and process Service Authorizations based on the National Provider Identifier (NPI, See Section 40.3.2.6, Provider Enrollment Administration Contractor Responsibilities, Item 4).
2. Process Service Authorizations:
   a. Enforce the rules defined in the Service Authorization Rules Engine regarding services that require authorization;
   b. Process Service Authorization requests/amendments according to State-approved guidelines, time constraints, and provide automated real-time responses to providers of their approved, denied, or pending status;
   c. Update Service Authorization records based upon claims processing results indicating that the authorization has been partially used or completely used;
   d. Process Service Authorizations for non-covered services per State guidelines set in the Rules Engine and workflow management system;
   e. Provide a means to perform mass updates of Service Authorization records; for example: provide capability to globally change provider ID numbers or procedure codes or modifiers on pending service; and
   f. Identify service categories that are subject to the same limitation and accumulate the like services.
3. Maintain Service Authorizations:
   a. Convert all existing Service Authorizations and historical Service Authorizations to new defined format(s);

b. Provide all data element fields and claims rules necessary to enforce Service Authorization requirements;

c. Provide the capability for authorized State staff and consultants to edit requests and enter approvals and denials online;

d. Provide the capability to restrict authorization based on:

(1) Units of service;

(2) Dollar amounts;

(3) Diagnosis Codes;

(4) Procedure codes or related procedure events;

(5) Calculated or negotiated amounts;

(6) Date ranges;

(7) NDC;

(8) Generic Code;

(9) Therapeutic Class; and

(10) Provider Number.

e. Provide online access to approval and denial letters sent to providers and recipients for stipulated time frame;

f. Track, identify, and display online the location of each authorization request, the individual assigned to it, and the length of time at a review location;

g. Automatically close Service Authorization records after a State-defined time period;

h. Update Service Authorizations to correctly reflect claim adjustments and voids;

i. Purge Service Authorization records on a schedule determined by the State;

j. Maintain provider and recipient specific Service Authorization history using a variety of search capabilities to access the records; and

k. Provide simple mechanisms to update and correct a single Service Authorization record, or using a batch process, correct multiple Service Authorization records, including updates to dates, units, limits, status, recipients and provider information fields.

4. Reporting and communication of Service Authorizations:

a. Provide via a Web portal, secure and HIPAA-compliant email and/or by letter the status of all service requests to both the requesting provider and the recipient;

b. Operate a toll-free call center function to handle provider and recipient inquiries regarding Service Authorizations, including an Automated Voice Response System (AVRS);

c. Return to or notify providers of Service Authorization requests missing key data or received according to policy;

d. Generate and distribute State approved Service Authorization request forms and attachments to providers. These forms and attachments should be available through the Web portal for downloading and in hard copy format;

e. Provide user reporting on the following:

(1) Dollar value of services authorized;

(2) Cancelled or suspended authorizations;

(3) Duplicate authorizations;

(4) Utilization reporting;

(5) Provider and recipient authorizations history;

(6) Summary and detail reporting by provider/area Medicaid office/waiver program/PRO on number of Service Authorizations requested, approved, modified, or denied;

(7) Outstanding Service Authorizations (authorized but unused services); and

(8) Summary and detail reports to track and summarize Service Authorizations process by adjudication mode (e.g., automated or manual).

f. Propose a system-automated solution for Service Authorization requests submitted for the Medically Needy (spenddown) population. The Department of Children and Families (DCF) captures all spenddown information in the Florida System, because a recipient is not eligible for Medicaid until the monthly spenddown amount is met. When a service requires Service Authorization and the recipient's share cost (spenddown) has not been met, provide a mechanism to allow entry of contingent Service Authorization;

g. Provide written Notice of Denial to recipients for Service Authorization denials and rejections in accordance with State policy;

h. Study and analyze all relevant programs and operating procedures in the current FMMIS as it is being operated during the period of Design and Development Phase, including all relevant Customer Service Requests and contract amendments:

(1) Formulate the initial business rules for this business process based on the current MMIS operations;

(2) Submit the proposed rules to the State for approval;

(3) Enter those rules approved by the State into the Rules Engine;

(4) Test the rules to assure they process as expected, compared to current FMMIS operations; and

(5) During the Readiness Testing Period, demonstrate the accuracy of rules application by proving the comparison to current fiscal agent operations; document and explain any differences to the satisfaction of the State.

i. Provide reports of Service Authorizations issued for use by Peer Review Organizations or other State-designated staff or entities in a format to be approved by the State during the Design and Development Phase.

5. Monitor quality and work toward continued quality improvement:

a. Provide information from reviewers independent of the staff performing the Service Authorization function;

b. Report on quality compared to previous periods through the Performance Reporting System;

c. Report specifically on:

(1) Number of Service Authorization approvals and denials; and

(2) Other items as determined by the State.

d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

e. Document and implement corrective action plans when requested by the State.

40.4.3 Cost Avoidance and Coordination of Benefits (COB) Business Processes

40.4.3.1 COB Overview

The Cost Avoidance and Coordination of Benefits (COB) business processes are an integral part of FMMIS/DSS and Florida's efforts to maximize Medicaid benefits for eligible recipients. The Contractor, through the COB functions, provides an important supporting role in achieving the State's goals.

The Contractor must use a Rules Engine (See Section 40.4.4, Claims Processing Administration) to set rules for claims payment, including cost avoidance measures and hierarchies of third party liability. The State will post changes to the rules or require the Contractor to make changes in the rules for processing claims with actual or suspected third party liability.

The Contractor must establish a cost recovery program and is encouraged to partner with an expert subcontractor. The Contractor and/or subcontractor must propose methods and plans to maximize recoveries from third parties.

40.4.3.2 COB External Interfaces

1. Agency for Workforce Innovation (worker's compensation);
2. Department of Highway Safety and Motor Vehicles;
3. Insurance carriers;
4. Medicare carriers/intermediaries and Coordination of Benefits contractors (COBC) when in place;
5. FLORIDA System (Department of Children and Families);
6. Income Eligibility Verification System (IEVS);
7. TRICARE;
8. Bureau of Vital Statistics;
9. State of Florida employees insurance plans;
10. Cost Recovery subcontractor as applicable;

11. Contingency fee contractors; and
12. CMS quarterly files of NDC codes available for rebate.

40.4.3.3 COB Inputs

1. Agency for Workforce Innovation (worker's compensation);
2. Department of Highway Safety and Motor Vehicles;
3. Insurance carriers;
4. TRICARE;
5. State of Florida employees insurance plans;
6. Contingency fee contractors;
7. Medicaid Carriers/intermediaries and Coordination of Benefits contractors (COBC) when in place;
8. CMS quarterly files of NDC codes available for rebate;
9. Department of Children and Families; and
10. FMMIS/DSS recipient, claim and encounter files.

40.4.3.4 COB Outputs

1. Claims and bills to other payers in electronic (837) and hard copy (claim form) media;
2. Bills to Florida counties;
3. Billing tapes to drug manufacturers for rebates;
4. Retroactive Part B Medicare enrollments;
5. Adjusted paid claims history for TPL recoveries;
6. TPL and cost avoidance reports; and
7. CMS-64 Report, TPL Section.

40.4.3.5 COB State Responsibilities

1. Collect third party resource information from outside sources;
2. Prepare and initiate agreements with insurance companies, governmental agencies, and other entities for performing data matches between their files and FMMIS/DSS recipient file;
3. Reconcile and make adjustments to third party insurance billings generated by the Contractor. These billings are generated from claims within the approved "pay and chase" category, where liability is indicated on the TPL Resource file;
4. Follow up on third party file discrepancies;
5. Perform certain maintenance on FMMIS/DSS TPL-related files, including files for TPL carrier billing file, recipient files regarding TPL Resources, and the Rules Engine for TPL cost avoidance;

6. Initiate and interpret all policy and make administrative decisions regarding third party liability;
7. Retain the ownership of all TPL information including insurance payment information;
8. Determine the interface criteria for data matches;
9. Monitor the drug rebate process; and
10. Approve HIPP.

40.4.3.6 COB Contractor Responsibilities

1. Design, develop, implement, and operate FMMIS/DSS TPL and COB functions to ensure all appropriate third party payments are identified, received, and applied:
   a. Allow for the entry of TPL and COB rules by State staff or Contractor staff as defined by the State;
   b. Apply TPL and cost avoidance measures entered by the State or given to the Contractor for entry;
   c. Identify third party resources available to Medicaid recipients, and determine third party resources liable for payment of services rendered to Medicaid recipients;
   d. Provide all necessary support as required or requested by the State in connection with its contingency fee contracts with Third Party Administrators (TPAs) for the detection and collection of third party resources;
   e. Provide all necessary support as required or requested by the State in connection with matching FMMIS/DSS recipient files with insurance companies, governmental agencies, or other entities as determined by the State, including update of FMMIS/DSS Insurance Resource file and Paid Claim History file;
   f. Perform quarterly match of Income Eligibility Verification System (IEVS) data received from the FLORIDA system to FMMIS/DSS eligibility file and prepare and mail as appropriate notification letters to matched employers;
   g. Provide the State the capability to update recipient TPL Resource files by tape or other batch interface;
   h. Provide capability to accommodate different claim resolutions for different Medicaid services and different policy limits, for claims pended for TPL review;
   i. Provide the capability to receive and process electronic TPL claim attachments as standard transactions are implemented;
   j. Maintain National Carrier Identification codes and apply them to the TPL process as national codes are assigned; and
   k. Provide a simple mechanism to correct or complete outdated TPL information.
2. Manage Accounts Receivable/Payable and all TPL/COB monies:

a. Manage the accounts as the invoices are paid, including posting payment, recording unit rebate amount changes, recording disputed items, adding or adjusting interest, and moving credit balances to current invoices;

b. Submit all checks received for TPL to the State for processing;

c. Provide improved and automated capabilities to identify and apply TPL recoveries in the following situations:

   (1) Pay and Chase (Federal requirements dictate when a claim must be paid and the TPL amount recovered vs. cost-avoided.);

   (2) Casualty and Estate Recovery (Resolve all litigation with recipient's attorney.);

   (3) TPL Case Management/Tracking (including case management functionality to manage and track all TPL subrogation functions.); and

   (4) Trauma or Accident Claims (using specific criteria, such as diagnosis, procedure codes and dates of service, identify and be able to prorate recoupments from auto, accident, home-owners or other policies when appropriate.)

d. Adjust claims for recoveries;

e. Provide capability to account for claim specific and non-claim specific TPL recoveries (Gross Adjustments);

f. FMMIS/DSS must automatically generate Health Insurance Premium Payment (HIPP) payments for eligible recipients:

   (1) Generate premiums based on a variable frequency (weekly, monthly, annually, and on-demand) based on start and/or stop dates;

   (2) Track and display premium amounts by date segment for the recipient;

   (3) Report cost-effectiveness of HIPP payments and produce other reports as determined by the State; and

   (4) Coordinate premium payments with the Bureau of Vital Statistics to ensure that no payments are made after the date of death of the recipient.

g. Include data, track changes, and maintain recipient co-pay and coinsurance requirements within the benefit plan component to ensure that co-pay and coinsurance amounts are up-to-date;

h. Process County Billing as directed by the State:

   (1) Prepare detailed monthly billings in formats to be approved by the State based on claims and encounter data submitted by inpatient hospitals, nursing homes, intermediate care facilities, MCOs and others;

   (2) Receive and process adjustments, payment information and update information supplied by the counties;

   (3) Calculate and maintain accounts receivable ledgers and reports detailing and totaling the amounts due from each county;

   (4) Issue bills, adjustments, rebills and statements for county billing, including both paper and Web-based forms;

(5) Allow State staff to enter and record amounts received in payment of County Billing receivables;

(6) Use information gathered in this process and rules supplied by the State to determine the amount of outpatient billings chargeable to the Public Medical Assistance Trust Fund (PMATF); and

(7) Provide access on the Web portal for counties to view their bills and update information; and

i. Calculate Medicaid recovery amounts for the claims identified, and track all TPL subrogation functions. Prior to implementation, the new Contractor will be responsible to convert data in the existing tracking system (EAGLE) into the new case management tracking system.

3. Manage drug rebate process:

a. Identify all rebate eligible claims;

b. Calculate rebate amounts and generate and track invoices to drug manufacturers for each existing drug rebate program and future programs;

c. Reconcile invoice to payment;

d. Handle disputes with manufacturer;

e. Compare NDC unit rebate amounts supplied by the manufacturer directly with the same information supplied by CMS;

f. Provide access to claim-level drug rebate information online. Provide the ability to update drug rebate information related to a claim when claim is updated in FMMIS/DSS;

g. Initiate the drug rebate process within two weeks of receipt of the CMS tape;

h. Make available through the Web portal a secure method for drug manufacturers to access and download their invoices;

i. Maintain a history of the Rebate Master file supplied by CMS;

j. Receive and process drug rebate checks;

k. Process Part D Medicare information for dual eligibles as directed by the State;

l. Create drug utilization tapes and reports, with formats and distribution directed by the State; and

m. Balance the tapes supplied by the manufacturers, including quarterly Reconciliation of State Invoice (ROSI) and Prior Quarter Adjustment (PQA) tapes.

4. Implement the X12 269 Health Care Benefit Coordination Verification Request and Response transaction:

a. Negotiate and secure trading partner agreements with major insurance carriers and health plans to perform TPL/COB verification as reported in these transactions; and

b. Create and implement a process to verify, whenever possible, the actual amounts paid by other carriers for services being billed to Medicaid, and adjust Medicaid payments according to rules set by the State.

5. Report, maintain, and track TPL and COB activities:

   a. Analyze all claims with trauma related diagnosis codes to determine if potential third party liability exists. Prepare Potential Trauma Leads Report on paper and CD-ROM;

   b. Maintain a post payment billing module, including monthly reports by carrier, of amount billed, amount re-billed, amount purged, and amount outstanding, for sources within the approved "pay and chase" category and retroactive for claims when insurance is added to the file, and where liability is indicated on the TPL Resource file cost avoidance matrix;

   c. Prepare reports of hospital provider paid claim history for the period determined by the State and when requested by the State;

   d. Prepare retroactive reports (reverse crossover) to Medicare Part B or the provider, as appropriate, for all claims paid by Medicaid that should have been paid by Medicare Part B. This reporting is necessary when Medicare Part B eligibility is applied retroactively to Medicaid recipients;

   e. Provide all data necessary to complete the third party section of the CMS-64, Quarterly Report of Expenditures;

   f. Provide a data file with Third Party Liability information, including recipient identifiers and all known insurance carriers, policy numbers, and carrier contact information. Produce and distribute quarterly to all Medicaid providers and the State Medicaid Area Offices and weekly to the FLORIDA System;

   g. Provide auditing reports for tracking by the State. These reports will be identified during the Requirements Analysis Task;

   h. Produce reports to determine the amount of outpatient billings chargeable to the Public Medical Assistance Trust Fund (PMATF);

   i. Produce lead letters and track original and follow-up letters to providers or recipients regarding TPL information when identified TPL information is indicated on a claim;

   j. Provide for a case management tracking system to interface with the DSS for historical claim information retrieval;

   k. Retain copies of invoices and correspondence as directed by the State;

   l. Provide capability to maintain historical data on TPL resource records as well as a hierarchy of coverage types for update purposes;

   m. Provide the capability of identifying and displaying the details of a recipient's TPL coverage, including encounter data; and

   n. Propose a solution to identify possible money recovery for accident cases.

6. Monitor quality and work toward continued quality improvement:

   a. Provide information from reviewers independent of the staff performing the COB function;

b. Report on quality compared to previous periods through the Performance Reporting System;

c. Report specifically on:

(1) TPL/COB audit activities; and

(2) Other items as determined by the State.

d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

e. Document and implement corrective action plans when requested by the State.

40.4.4 Claims Processing Administration

40.4.4.1 Overview

Claims Processing Administration is a new concept for this contract, based on the State's initial steps toward MITA compliance. This business process is used to define all criteria for assembling necessary reference files and fee schedules for the processing of claims and encounters.

FMMIS/DSS must use a Rules Engine to allow State users to define the processing requirements for claims and encounter data, including edits and audits for proper payment, Service Authorization and cost avoidance. The Rules Engine may be combined with a workflow management engine to create an organized, hierarchical process to receive, adjudicate, and record claims.

The Rules Engine must be flexible enough for the State to create an adjudication hierarchy that takes into consideration the recipient's benefit plan, provider and provider network information, reference information, information from claims payment history and information on the current claim.

FMMIS/DSS reference files and fee schedules must be available to State and Contractor staff through a Web-based interface. Reference files will include:

1. Diagnosis Codes (The system currently contains the ICD-9-CM coding in the Reference Subsystem. ICD-10 will probably be mandated for use by the time the new contract is awarded. Therefore, the new system must have the capability to accept ICD-10 and future formats implemented by CMS);
2. Procedure Codes (CPT, HCPCS, NCPDP, CDT, NDC);
3. Pricing and Rate tables for the various Provider Classes and Benefit Plans by date range;
4. Rates set for HMOs and other managed care plans;
5. Rules for editing and auditing claims and encounters;
6. Rules for Coordination of Benefits (COB), including cost-avoidance hierarchy and spenddown;
7. Exception codes;
8. Explanation of Benefit Codes; and

9. Utilization Review Criteria.

40.4.4.2 Claims Processing Administration External Interfaces

1. ICD-9-CM/ICD-10 updates;
2. CMS supplied HCPCS updates;
3. CPT and CDT updates;
4. HIPAA mandate external code sets;
5. HIPAA transaction updates; and
6. Fee schedules, rate tables and files supplied by the State.

40.4.4.3 Claims Processing Administration Inputs

1. Modifications to claims processing rules entered into the Rules Engine by the State or given to the Contractor for entry;
2. Modifications to the workflow process entered into the workflow engine by the State or given to the Contractor for entry;
3. Batch updates to code and reference files; and
4. Batch updates to fees and rate tables.

40.4.4.4 Claims Processing Administration Outputs

1. Changes in claims processing rules;
2. Audit trail reports of changed data;
3. Listings of the Procedure, Diagnosis, Drug, Revenue Code, Medical Criteria, and other tables based on variable, user-defined select and sort criteria, with all pertinent record contents on one listing;
4. All relevant pricing data for claims processing;
5. Explanation of Benefits (EOB) codes and text explanations;
6. Exceptional claims processing instructions, routing and files; and
7. Text alerts and provider notices for dynamic application based on claims criteria.

40.4.4.5 Claims Processing Administration State Responsibilities

1. Establish all policy regarding claims administration:
    a. Determine required edits, audits, and service limitations;
    b. Originate file maintenance updates relating to reference tables;
    c. Determine and interpret policy and make administrative decisions relating to the reference files;
    d. Establish specific pricing methodologies for all procedure and drug files and establish all rates, fees, and other pricing instructions, and authorize all pricing updates;

e. Review HMO and other reimbursement rates calculated by the Contractor, make modifications and set monthly per member per month (PMPM) rates for recipients enrolled in an HMO; and

f. Establish and approve all policies governing all codes, including but not limited to procedure, drug and diagnosis codes, new medical procedures, and codes that have duplicate or conflicting information.

2. Identify requirements for exceptional claims processing, including Service Authorization requirements, second surgical opinions, diagnosis restrictions, manual pricing, and other requirements, and approve the workflow for each restriction;
3. Authorize override of claims edits to force-pay specific claims;
4. Establish appropriate timeframe requirements for additions, corrections, and deletions to reference system data elements; and
5. Establish and approve the use of all Explanation of Benefits (EOBs), reason, remark, and reject codes to ensure clarity in interpretation.

40.4.4.6 Claims Processing Administration Contractor Responsibilities

1. Maintain and operate all FMMIS/DSS reference files and tables needed to process claims and encounter data, including improvements as they are implemented:

   a. Develop claims processing rules-engine;

   b. Update all reference file data, HIPAA mandated code sets, approved versions of HCPCS procedure codes, ICD-9-CM/ICD-10 diagnosis and procedure codes, CDT procedure codes, revenue center codes, DSM diagnosis codes, NDC drug codes, DRG diagnostic related groups, State budget appropriation codes, and any other codes as required by the State;

   c. Provide to State and Contractor staff online access to updates of reference files as well as update capabilities in batch mode;

   d. Provide the State online access to an audit trail of all changes made to the system by user and by date and time, and audit trails for all batch updates;

   e. Provide access to all reference files for viewing and export to PC-based software for any authorized user;

   f. Provide reference extracts as approved by the State on the Web portal available to Medicaid providers;

   g. Provide access to all fee and rate tables for viewing, update and export to PC-based software for State-authorized users;

   h. Provide detailed system documentation on all system edits and audits that reflects the adjudication process in FMMIS/DSS. The documentation must be accessible via a Web portal. The level of detail will be provided by the State;

   i. Contract for drug file updating services, subject to State approval, and create an automated process to update drug file data from magnetic tapes or other media supplied by the drug file contractor and by manual updates as supplied

by the State. Manual updates supplied by the State will be entered into the FMMIS within one (1) workday of receipt;

j. Resolve TPL and ProDUR issues at the time of the POS transaction;

k. Accommodate variable pricing methodologies for identical procedure codes based on Benefit Plans, recipient data, provider networks and provider specific data;

l. Maintain current and historical reference data, assuring that updates do not overlay or otherwise make historical information inaccessible. All current and historical data in reference files must have online inquiry capability;

m. Allow notes to be posted to reference files using online notes capability;

n. Provide the capability to identify surgical procedures subject to, or exempt from, multiple surgery reimbursement cutbacks;

o. Apply negative audit relationships (e.g., do not pay for procedure unless another procedure code was paid during a specified time);

p. Provide the functionality to fully customize any combination of bundling/unbundling of service procedure codes via a Web portal using a rules-based engine; and

q. Contain the functionality to increase or decrease payment for a procedure based on a historical previously paid claim(s).

2. Apply a variety of claims pricing methodologies. Additionally, the new system must have the ability to perform online and real-time changes to pricing methodology and accommodate pricing rule changes. Only authorized users should have the security clearance to make changes to pricing and pricing rules. Pricing segments and rules must be date sensitive to allow accurate processing and pricing of claims based on the date of service. Pricing methodologies that may be used include:

a. RBRVS and modifiers;

b. Fee based procedures;

c. Procedure code groupings;

d. Per diem;

e. Cost based per visit rate;

f. Fees based on provider charges;

g. Capitation;

h. Flat rates;

i. Mileage;

j. All-inclusive rates;

k. Percent of billed charges;

l. Negotiated rates;

m. Manual or automated pricing;

n. Diagnosis based pricing;

o. Time-unit pricing;

p. Retroactive rate adjustments;

q. Dispensing fees;

r. Drugs grouped by generic code, therapeutic class, NDC or other code sets determined by the State; and

s. Other pricing methodologies as determined by the State.

3. Provide reference files to record State Area Office information including office addresses, telephone numbers for certain contacts, and email addresses for various purposes;

4. Provide methods and tables necessary to edit and process claims:

   a. Approve, adjust, re-price, suspend, or deny claims based on any criteria in the claim, provider files, recipient files, reference files or the Rules Engine; and

   b. Allow any rule to be applied at the claim header or claim detail level.

5. Calculate rates for HMOs, other Benefit Plans, and for each category of service within the Benefit Plan using State-approved and actuarially sound methods. At the direction of the State, these methods may include methods like any or all of the following:

   a. Analysis and stratification of claims paid for similar profile groups in the fee-for-service sector, adjusting for new programs or services, and applying State-negotiated discounts. Stratification may be based on age, location, eligibility category, service, disease condition and other factors;

   b. Application of national norms for similar profile groups;

   c. Analysis of encounter data;

   d. Application of negotiated rates;

   e. Any combination of the above; and

   f. Post rates to fee tables for use in claims processing.

6. Study and analyze all relevant programs and operating procedures in the current FMMIS as it is being operated during the period of Design and Development Phase, including all relevant Customer Service Requests and contract amendments;

   a. Formulate the initial business rules for this business process based on the current MMIS operations;

   b. Submit the proposed rules to the State for approval;

   c. Enter those rules approved by the State into the Rules Engine;

   d. Test the rules to assure they process as expected, compared to current FMMIS operations; and

   e. During the Readiness Testing Period, demonstrate the accuracy of rules application by proving the comparison to current fiscal agent operations; document and explain any differences to the satisfaction of the State.

7. Identify and use a COTS product or subcontractor service to validate claims:
   a. Apply national norms and standards to determine service limitations, bundling and unbundling of services, service duplications and any relevant edits that should be applied to pay claims according to nationally accepted standards;
   b. Provide for State review of all proposed validation edits. Apply only edits approved by the State;
   c. Provide for automatic claim denial or cutbacks in amounts paid based on validation edits;
   d. Incorporate claim validation into claims processing as a separate process or in conjunction with the Rules Engine;
   e. Integrate accurate reporting of denials or cutbacks into claims processing with HIPAA-compliant Explanation Of Benefits (EOB) Codes.
8. Monitor quality and work toward continued quality improvement:
   a. Provide information from reviewers independent of the staff performing the Claims Processing Administration function;
   b. Report on quality compared to previous periods through the Performance Reporting System;
   c. Report specifically on:
      (1) Updates to Reference files; and
      (2) Other items as determined by the State.
   d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and
   e. Document and implement corrective action plans when requested by the State.

40.4.5 Adjudication of Claims and Encounters

40.4.5.1 Adjudication of Claims and Encounters Overview

The adjudication of claims and processing of encounters provides for the capture, control, editing and auditing for claims data from the time of initial receipt (on hard copy or electronic media) through to final disposition. The Contractor must operate this process according to the policies, procedures, and benefit limitations of the Florida Medicaid Program.

The adjudication process includes the manual, electronic, and computerized operations necessary to receive, review, approve or disallow, and pay claims and process encounters according to State requirements. All provider claims for Medicaid services are adjudicated within this process.

Claims and their supporting attachments are accepted through online exam entry, key entered through a data entry system, OCR, magnetic tapes, electronic submission, and Web submission. All electronic claim and encounter submissions must be in the HIPAA compliant format. It also includes the ability to process automated and provider submitted Medicare crossover claims, and generate and

adjudicate capitation claims for recipients enrolled in all managed care plans. FMMIS/DSS must include a Web portal to present long term care institutions with their list of residents from the preceding month and allow quick, Web-based data entry of changes, additions and deletions for processing (replaces current turnaround document processing).

The Contractor must carry out this process based upon the rules established by the State using FMMIS/DSS functions governed by the Claims Processing Administration business function, including the approved workflow for automated claims processing and the approved manual workflow for exceptional claims. In the processing of claims, the Contractor must also apply ProDUR edits according to rules set in the Claims Processing Administration business function.

All paper claims must be screened for minimum requirements approved by the State. Paper claims failing to meet minimum requirements will be returned to the provider without imaging or processing under a protocol approved by the State. Paper claims that meet minimum requirements must be imaged for reference. Images must be easily accessible by hyperlink from any FMMIS/DSS claims display screen. Paper claims must be marked with the Transaction Control Number (TCN) to be used by FMMIS/DSS before imaging.

Data from paper claims must be converted into a HIPAA compliant electronic transaction for continued processing.

The Contractor must have an exact system to balance claims, to know the location and status of every claim record and ensure that every claim received has been properly adjudicated.

40.4.5.2 Adjudication of Claims and Encounters External Interfaces

1. File Transfer Protocol (FTP);
2. Magnetic tape;
3. Pharmacy Point of Service (POS) System;
4. TCP/IP site for claims and encounter data submission;
5. Telephone/modem dial-in site for claims and encounter data submission; and
6. Web portal.

40.4.5.3 Adjudication of Claims and Encounters Inputs

1. Paper claims in standard formats including CMS-1500, UB-92, UB-04, Pharmacy UCF, dental and other industry standard forms that may replace them;
2. State of Florida claim forms;
3. Electronic media claims and encounter data;
4. Long Term Care;
5. Paper and electronic attachments;
6. Medicare Crossover claims; and
7. COB claims.

40.4.5.4 Adjudication of Claims and Encounters Outputs

1. Adjudicated claims and encounters;
2. Suspended claims and encounters;
3. Long Term Care;
4. Adjudication reports;
5. Suspense reports;
6. Balancing reports; and
7. Tracking reports.

40.4.5.5 Adjudication of Claims and Encounters State Responsibilities

1. Establish and provide rules governing the adjudication of claims and encounters:
   a. Enter or supply to Contractor staff for entry all rules for the adjudication of claims and encounters;
   b. Determine which coding systems will be used in the system for medical procedures, diagnoses, and drugs;
   c. Supply instructions for exceptional claims resolution, including policy interpretation, coordination of State units, responses to inquiries by public officials, other governmental agencies, or other special interest groups; and
   d. Provide instructions for out-of-state claims processing.
2. Provide Medicaid Quality Control (MQC) and review procedures:
   a. Perform MQC functions in accordance with federal and State laws and all regulations;
   b. Review and approve Contractor MQC procedures to verify keying quality as well as proper performance of all ECS functions;
   c. Determine and interpret policy and make administrative decisions relating to MQC;
   d. Approve and monitor corrective actions resulting from MQC findings;
   e. Monitor all stages of claims processing, including screening, imaging, data entry, receipt of electronic media, automated claims and encounter adjudication, exceptional claims processing, claims balancing, quality control and auditing. This will be done both by reviewing Contractor reports on all of these items and by physical access to and inspection of all of the processes on an ongoing basis and without any advance notice to the Contractor; and
   f. Review and approve the downtime standards for scheduled maintenance of FMMIS/DSS and the pharmacy POS system.
3. Approve the design of any allowable State claim forms. Approve the data requirements for paper, tape and other electronic billings, including Medicare crossovers;
4. Provide medical consultants to review exceptional claims for reasons as defined by the State;

5. Provide liaison for Medicare crossover claims;
6. Approve ProDUR criteria for drug interaction, therapeutic duplication, and other ProDUR criteria; and
7. Approve fiscal agent contracts with telecommunication vendors to support real-time claims submission and responses.

40.4.5.6 Adjudication of Claims and Encounters Contractor Responsibilities

1. Create, develop, and maintain a claims and encounters adjudication system based upon the rules defined within the Claims Processing Administration;
2. Receive and process multi-page CMS-1500 forms up to 50 lines long as a single claim;
3. Provide a Web portal allowing long term care facilities to manage their recipient rosters, and submit claims (replaces nursing home turn-around document (TAD) process):
   a. Allow the facility to perform adds, changes and deletes of recipients in their facility;
   b. Allow the facility to update the number of days in the institution, days spent at home, and the days spent in the hospital; and
   c. Process the long term care rosters on a monthly basis to facilitate payment long care facilities.
4. Allow for the entry and submission of claims and encounters:
   a. Screen paper claims to verify provider information and verify that services are reported on the appropriate claim forms and that provider and recipient identification and the provider signature are present, and that any other minimum requirements of the State are met. Return to the provider claims missing any of these key data elements or submitted on an inappropriate claim form;
   b. Print the TCN on the claim and attachments so that the TCN remains visible on both the original and imaged forms;
   c. Perform imaging and data entry of claims that pass the prescreening process;
   d. Maintain a Web portal for providers to directly and efficiently enter claims, submit batches of claims using FTP, view claim status, view remittance vouchers, receive check amounts and other payment information, submit adjustments and voids, and view notices;
   e. Maintain dial-in line(s) for claims submission. Maintain sufficient telephone lines to receive all calls by providers for electronic transmission of Medicaid claims. Maintain at least a ninety (90) percent answer rate on provider submission telephone lines;
   f. Provide secure, HIPAA compliant software and documentation, for Windows operating system (98 SE or above) , for use by providers to submit electronic claims, through TCP/IP transactions, via FTP, or through a dial-up telecommunications network at no cost to the provider;

g. Verify that all providers submitting are properly enrolled at the time of service and allowed to submit electronically;

h. Provide imaging and scanning and automated software that provides for accurate and timely entry of paper claims. This software should include field data edits to identify erroneous data and allow for online compariosn of the data with the image for correction;

i. Maintain copies of all imaged claims, attachments and facsimiles of electronic billing input for a period of seven (7) years and make images available through hypertext links from any claims online screen;

j. Employ Caller ID technology to verify that the calling number is authorized and the submitter is authorized to submit transactions electronically;

k. Receive and adjudicate pharmacy claims (including compound drug claims) submitted by the pharmacy providers via the point-of-service (POS) process in a real-time mode;

l. Accept and store all fields on the 837 HIPAA claim transactions. The State will identify which fields are needed to process the claim;

m. Process all approved HIPAA transactions from Florida Medicaid providers;

n. In processing batch 837s that contain syntactically correct and incorrect transactions, process the correct transactions and reject the incorrect transactions, rather that rejecting the whole batch;

o. Accept HIPAA transactions that contain multiple transactions types in the same electronic envelope;

p. Provide methods and allow providers to submit test files for electronic claims submission that are processed through the adjudication cycle. Allow providers to submit test files whenever they change billing agent, change software, or request testing to resolve billing problems. Assure that all testing is controlled so tested items are excluded from actual production. Test and report to providers:

(1) Transmission success or failure;

(2) HIPAA compliance;

(3) Test adjudication results; and

(4) Recommendations to correct billing errors.

q. Provide a mechanism to receive and process Service Authorizations based on the National Provider Identifier (NPI, See Section 40.3.2.6, Provider Enrollment Administration Contractor Responsibilities, Item 4).

5. Operate and maintain the adjudication of claims and encounters including improvements as they are implemented:

a. Maintain the security and operation of the entire set of computer programs and data files identified as part of the adjudication of claims and encounters;

b. Establish balancing and control over all transactions during their entire processing cycle. All claims entering the system will contain a transaction control number (TCN). The TCN must be assigned to each claim within one (1) workday of receipt;

c. Account for any non-compliant claims received, but do not adjudicate. If a trading partner agreement exists with the submitter, return appropriate HIPAA transaction, rejecting the claim; otherwise, do not process further;

d. Adjudicate all out-of-state claims and process encounters per the State's processing instructions;

e. Identify claims from out-of-state providers and apply State defined out-of-state payment methodology. FMMIS/DSS must indicate the specialty of out-of-state hospitals and pay the facility according to either the negotiated rate or Medicaid rate or other payment rate as directed by the State;

f. Provide an audit trail on all claim transactions from time of receipt to time of payment so that a claim may be located at any time and so that all failed edits can be identified;

g. Maintain and staff a claims resolution unit to resolve exceptional claims. The Contractor must provide sufficient staffing to resolve all exceptional claims that can be resolved subject to Contractor review within seven (7) workdays. The unit will maintain a close working relationship with the State in developing and writing the resolution instructions for the unit, and in resolving claims in accordance with program policy and procedures;

h. Process up to four procedure modifiers, in serial fashion, and correctly route for review and claims processing;

i. Provide the capability to edit nursing home leave days for hospitalization vs. the actual length of the hospital stay and to adjust a LTC facility's payment based on leave days;

j. Set and display an unlimited number of edit failures per claim;

k. Maintain the adjudicated claims history file that contains all transactions processed to final disposition. Claims adjudicated within the past seven (7) years must be available online; and

l. Determine if reprocessing should occur if a new edit is added to the system through the Rules Engine. With the State's concurrence, re-adjudicate all affected claims within seven (7) workdays of adding the edit in the Rules Engine.

6. Provide for the reporting and tracking of all claims and encounters:

a. Provide the State with electronic images of hard copy original claims, adjustments, attachments, and Service Authorizations for all transactions processed in each adjudication cycle, prior to the scheduled provider check write time. All imaged copies of these claims and related documents must be certified to be legible by the State prior to the destruction of paper claims;

b. Provide detailed claims listings and copies of claim forms for all claims selected for Medicaid Quality Control (MQC) analysis within seven (7) workdays to Medicaid Program Integrity and for use by the State Auditor General's office. Assist the State in selection and collection of MQC samples;

c. Submit to the State, on a schedule to be determined by the State, all claims adjudication reports. Produce all management and audit reports timely and accurately on a schedule determined by the State;

d. Provide the functionality to allow authorized users the ability to query a vendor's drug payment history file and print it; and

e. Provide easy and logical access for State staff to view lists and details of all claims, encounters, Service Authorizations, reference files, and all FMMIS/DSS records by recipient, provider, data range, category of services or other specification requested by the State.

7. Adjudicate all claims by accurately applying rules and workflows defined by the State in Claims Processing Administration to the point where either:

   a. The claim is set to pay or deny and all relevant EOB codes are posted to the claim, or

   b. The claim is determined to be an exceptional claim, is set to suspend, and is routed according to the rules and workflows defined by the State in Claims Processing Administration.

8. Adjudicate all claims as indicated above according to the following schedule:

   a. Adjudicate all POS claims within 2.5 seconds of receipt at the switch;

   b. Provide HIPAA compliant acknowledgement transaction within 2.5 seconds of claims receipt;

   c. Adjudicate online claims received via Web submission or TCP/IP transmission within 30 minutes of receipt;

   d. Adjudicate all other electronic claims within one (1) workday of receipt; and

   e. Adjudicate all paper claims within twenty (20) workdays of receipt.

9. Suspend and process suspended claims applying rules and workflows defined by the State:

   a. Allow claims to be suspended for any reason determined by the State, whether related to provider status, recipient status, or application of edits as the claim is processed;

   b. Provide for automatic reprocessing of suspended claims under rules approved by the State;

   c. Provide mechanisms for State and Contractor staff to work suspended claims to approve or deny specific line items or entire claims; and

   d. Manually or automatically work all suspended claims. Except as agreed in State approval of workflow management steps, all suspended claims must be reprocessed within three (3) days of receipt of the information necessary to resolve the claim.

10. Monitor quality and work toward continued quality improvement:

    a. Provide information from reviewers independent of the staff performing the adjudication of claims and encounters function;

    b. Report on quality compared to previous periods through the Performance Reporting System;

    c. Report specifically on:

       (1) Number of claims and encounters processed;

(2) Compliance with claims adjudication schedules; and

(3) Other items as determined by the State.

d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

e. Document and implement corrective action plans when requested by the State.

40.4.6 Provider Payments

40.4.6.1 Provider Payments Overview

Florida Medicaid providers are currently paid once per week in a Payment Cycle. Claims set to pay or deny since the last Payment Cycle are collected and processed in the current week's Payment Cycle. The claim reimbursement amounts have already been computed in the adjudication process, according to all rules set in Claims Process Administration, including the application of all recipient-benefit limitations, third-party payments, and co-payment requirements. Payment amounts are aggregated by provider. Suspended claims are included in the Payment Cycle for reporting purposes only.

FMMIS/DSS must generate managed care capitation claims, administration and management fees for MediPass, and certain network providers and other time-triggered payments according to rules set in Claims Processing Administration and include payment in the appropriate Payment Cycle.

This process will check for any provider liens, provider credit balances (also called "negative balances"), and provider recoupments. The process deducts the appropriate amounts from the payments that are about to be made by issuing a negative transaction to the provider (for liens, a payment to the lien-holder is also produced). All financial transactions will appear on the provider's remittance voucher (electronic and hard copy).

Before checks or EFT transactions are issued, the Contractor must apply rules approved by the State to check for reasonableness of provider payments, including comparison of each provider's check to average amounts, review of the highest dollar payments by provider type, and review of payments to new or dormant providers. All suspect payments must be reported to the State, and at the State's direction, must be withheld from the payment cycle.

As part of the Payment Cycle, payment amounts are verified and balanced. Upon State approval, a warrant is issued to draw funds for the payment of providers by Electronic Fund Transfer (EFT) or hard copy check/warrant.

The Contractor must maintain an electronic Accounts Receivable ledger. The ledger must be accessible to State staff for posting liens, amounts to be recouped, settlements, and payments. Authorized State staff must be able to view and produce reports on transactions to the ledger and provider balances.

40.4.6.2 Provider Payments External Interfaces

1. EFT (banking system); and
2. State of Florida Comptroller financial system.

40.4.6.3 Provider Payments Inputs

1. FMMIS/DSS adjudicated and suspended claims;
2. State entered or directed gross adjustments and history only adjustments; and
3. Provider alert text for remittance vouchers.

40.4.6.4 Provider Payments Outputs

1. Provider payments by EFT file and hard copy check;
2. Remittance vouchers;
3. HIPAA electronic transactions;
4. Updated paid/denied claims history file(s);
5. Updated provider lien balances;
6. Updated Accounts Receivable records;
7. Reports reflecting the provider payment process; and
8. Provider *alert text* to include with the remittance voucher.

40.4.6.5 Provider Payments State Responsibilities

1. Review all necessary reports to assure that the payment process is in balance and appropriate;
2. Release funds for deposits made to the Florida Medicaid Disbursement account for funding provider payments;
3. Enter or provide the Contractor with any lien or recoupment amounts to apply against provider payment; and
4. Enter, or provide to Contractor for entry, provider payment rules.

40.4.6.6 Provider Payments Contractor Responsibilities

1. Maintain the provider payments process:
    a. Allow for the entry of provider payments rules either by the State or Contractor at the State's direction;
    b. Execute the Payment Cycle every week on a schedule determined by the State. As part of the Payment Cycle, the Contractor must review and balance all outputs at critical processing points. After these have been reviewed and balanced by the Contractor, these inspection and balancing reports must be forwarded to the State;
    c. Include capitation payments, management, and administrative fees in the appropriate Payment Cycle as set by the Claims Processing Administration Rules Engine;
    d. Apply rules supplied by the State to check for reasonableness of each provider payment, report all suspect payments to the State as part of the inspection and balancing reports, and withhold checks or EFT transactions as directed by the State:
        (1) Identify checks that exceed an average threshold supplied by the State;

(2) Identify checks that are the highest amounts, above a threshold set by the State, within a provider type; and

(3) Identify checks for new providers or providers that have not billed in a long time, as determined by the State; and

e. Check for provider accounts receivable and deduct appropriate amounts.

2. Maintain control of all provider payments:

a. Produce and mail provider checks, Remittance Vouchers, banner messages and other provider-related materials produced by the Payment Cycle;

b. Provide Electronic Remittance Vouchers, text messages and other provider related material produced by the payment cycle;

c. Provide for the EFT for most providers, based on the current setting in the provider's enrollment files, and controlled by cost avoidance settings. Only in limited and defined circumstances authorized by the State will hard copy checks be issued;

d. Manually pull and void provider checks and remittance vouchers after printing at the State's request. In cases where the State instructs the voiding of a check, the Contractor must adjust (void) any claims associated with the check;

e. Remove EFT payments from the banking file prepared for EFT transfer file (scrub); pull and remove remittance vouchers at the State's request. In cases where the State instructs the voiding of a check, the Contractor must adjust (void) any claims associated with the check;

f. Submit to the State, on a State defined schedule, all reports generated from the Payment Cycle;

g. Hold checks and check stock in secure storage, and carefully audit and control check numbers and check stock. The Contractor must exert controls and counts to prove that every check produced was actually mailed;

h. Maintain a secure check vault that can only be accessed by a key/combination dual control system. Access can only be obtained when a key holder and a combination holder are both present. The Contractor must perform both system and manual check printing within the check vault;

i. Arrange for the special delivery of provider checks. Providers may receive funds by several methods including express mail, wire transfer, and office pickup;

j. Account for all manual checks issued. Manual checks may be required for the following or similar reasons:

(1) EFT rejects;

(2) EFT scrubs;

(3) Damaged system checks;

(4) Emergency advance payments;

(5) HMO newborn payments;

(6) Disproportionate Share payments;

(7) Internal Revenue Service Tax Levy payments;

(8) Agency Lien payments;

(9) Reissues for forged or improperly endorsed checks;

(10) Reissues for stop payment checks;

(11) Reissues for voided checks;

(12) Reissues for stale dated checks;

(13) Reissues for wire rejects;

(14) Reissues for miscellaneous refunds; and

(15) Mass Adjustment issues to the State for undeliverable checks, returned checks or stale dated checks.

k. Maintain Accounts Receivable, including the handling and accounting for emergency provider payments, liens, and recoupments;

l. Process miscellaneous provider personal checks received for provider refunds, criminal background investigations, handbooks, forms, etc;

m. Maintain a comprehensive list of all checks and EFT payments made for a provider available for online inquiry; and

n. Perform “Special Check Pulls”. These include such items as:

(1) Special handling requests;

(2) Undeliverable holds;

(3) State recoupment checks;

(4) IRS recoupments; and

(5) Pulling checks as directed by Medicaid Program Integrity.

3. Monitor quality and work toward continued quality improvement:

a. Provide information from reviewers independent of the staff performing the Provider Payments function;

b. Report on quality compared to previous periods through the Performance Reporting System;

c. Report specifically on:

(1) Number of provider payments;

(2) Number of provider checks;

(3) Number of special check pulls;

(4) Performance of Web-based interface to recipient eligibility information; and

(5) Other items as determined by the State.

d. Initiate, document and implement at the Contractor’s own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

e. Document and implement corrective action plans when requested by the State.

40.4.7 Adjustments and Voids

40.4.7.1 Adjustments and Voids Overview

FMMIS/DSS must have the capability to perform adjustment and void transactions to previously paid or denied claims or encounter data. These transactions occur due to provider rate changes, claims paid or denied in error, legislative budget mandates, and many other reasons. Adjustment/void transactions can take the form of a single claim adjustment or void, mass adjustment or void, and gross adjustment or void. Additionally, history only adjustment and voids are performed due to provider refunds, partial payments from third party insurers, for Medicaid Program Integrity purposes and as directed by the State.

Providers submit adjustment or void transactions in response to billing errors along with State initiated adjustment and void transactions. FMMIS/DSS must be capable of performing adjustments or voids on claims or adjustments adjudicated by FMMIS.

40.4.7.2 Adjustments and Voids External Interfaces

None at this time.

40.4.7.3 Adjustments and Voids Inputs

1. Manually entered adjustment or void transactions;
2. HIPAA 837 adjustment or void transactions;
3. Manually entered gross adjustment/void and mass adjustment/void transactions;
4. Adjustment or Void transactions created by FMMIS/DSS financial system; and
5. Adjustment or Void transactions submitted by providers through the Web portal.

40.4.7.4 Adjustments and Voids Outputs

1. Adjustment/Void audit trail reports;
2. Adjustment/Void control reports as specified by the State; and
3. HIPAA 835 Remittance Advices with correct adjustment/void information.

40.4.7.5 Adjustments and Voids State Responsibilities

1. Establish all adjustment and void processing rules, policies and procedures;
2. Review all mass adjustment and void output reports and verify correctness;
3. Enter, or supply to the Contractor for entry, adjustment and void processing rules; and
4. Approve all mass adjustments to be released for adjudication.

40.4.7.6 Adjustments and Voids Contractor Responsibilities

1. Design, develop, and implement the Rules Engine governing adjustment and void processing:

a. Allow the State or Contractor to enter rules applying to adjustments and voids;

b. Scan/image all paper adjustment and void requests;

c. Perform all State initiated adjustment or void requests;

d. Monitor the adjustment/void process for accuracy;

e. Provide the capability to process mass adjustment/void transactions or individual adjustment/void transactions;

f. Apply retro-rate adjustment transactions to claims for the previous seven (7) years as directed by the State;

g. Provide the ability to process credits and payments for long-term care drugs returned to stock for reuse; and

h. Allow providers to initiate individual adjustment and void transactions via a Web portal and view the prospective results of the transaction on the claim.

2. Maintain adjustment and void processing:

a. Perform reconciliation of dollar amounts of provider refunds with amounts applied to claim's history to ensure financial correctness;

b. Accept HIPAA 837 transactions for adjustment and voids;

c. Provide for, accept and process adjustment and void transactions submitted by providers through the Web portal;

d. Process adjustment/void criteria via batch input or online input by use of online screens, and provide an automated mass adjustment process to reprocess and reprice previously adjudicated claims (regardless of disposition) according to State specified circumstances;

e. Allow authorized users to select a previously adjudicated claim or group of claims to be reprocessed, adjusted, or voided based on State specified factors and claim data elements;

f. Provide the capability to edit and void/adjust previously adjudicated claims in the same pay cycle;

g. Provide the ability to adjust encounters that need to be paid FFS;

h. Ability to process mass adjustments/voids automatically that do not require the user to intervene on a claim-by-claim basis;

i. Perform history only void and adjustment to paid claims history at the direction of the State;

j. Maintain an online mass adjustment selection screen, limited to select users, to enter selection parameters such as date(s) of payment, date(s) of service, provider type(s), provider number(s), provider(s) class, recipient number(s), and claim type(s). Claims meeting the selection criteria shall be displayed for initiator review, and the initiator will have the capability to select or deselect chosen claims for continued adjustment processing;

k. Process all adjustments and voids of claims and encounter records using the rules for edits, audits, and pricing based upon the claim's dates of service;

l. Process credits and payments for long-term care drugs returned to stock for re-use;

m. Provide an automated adjustment process when there is provider change of ownership; and

n. Receive and process gross adjustments as directed by the State. Image all documents associated with the adjustment and provide hypertext links to images on all appropriate screens.

3. Report on adjustment and void processing:

a. Produce a Mass Adjustment/Void report itemizing all claims produced by the mass adjustment/void transaction along with the claims that the transaction affected. This will allow the State to determine whether to release the mass transaction for adjudication or allow the user to delete the adjustments/voids created by the transaction;

b. Maintain an audit trail containing reason codes and identifying the user that initiated the adjustment or void; and

c. Provide the online capability for Contractor staff, State staff and providers to view the complete history of a voided or adjusted claim in chronological order, including all associated transactions.

4. Monitor quality and work toward continued quality improvement:

a. Provide information from reviewers independent of the staff performing the Adjustments and Voids function;

b. Report on quality compared to previous periods through the Performance Reporting System;

c. Report specifically on:

(1) Number and of adjustments/voids received and processed;

(2) Dollar value of adjustments/voids received and processed; and

(3) Other items as determined by the State.

d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

e. Document and implement corrective action plans when requested by the State.

40.4.8 Provider Communications Regarding Payments

40.4.8.1 Provider Communications Regarding Payments Overview

The payment cycle must produce detailed remittance vouchers (RV) for the providers. Each statement must contain an itemized list of paid, denied, and suspended claims; explanations for reduced payment or denial; month-to-date and year-to-date payment information; and a provider alert (variable by provider type or provider class) to provide up-to-date information about the Florida Medicaid program.

Providers may receive the remittance voucher in hard copy form or electronic transmission. Additionally, the year's paid claims data will be used to support the production of provider 1099 forms.

40.4.8.2 Provider Communications Regarding Payments External Interfaces

None at this time.

40.4.8.3 Provider Communications Regarding Payments Inputs

1. Email;
2. Fax;
3. Personal Contact;
4. Telephone;
5. Provider Field Staff;
6. State Referral; and
7. Written Correspondence.

40.4.8.4 Provider Communications Regarding Payments Outputs

1. Accurate responses to provider inquiries regarding payments; and
2. Remittance vouchers.

40.4.8.5 Provider Communications Regarding Payments State Responsibilities

1. Establish all policy and rules applicable to provider communications;
2. Review and approve all form letters and written correspondence to providers;
3. Provide text for all RV provider alert text;
4. Monitor telephone inquiries to ensure the accuracy of information given to providers, customer service and courtesy on the telephone and that the Contractor meets State performance standards and reviews performance issues;
5. Refer payment related provider inquiries to the Contractor for response; and
6. Enter, or provide to Contractor for entry, provider communication rules.

40.4.8.6 Provider Communications Regarding Payments Contractor Responsibilities

1. Submit operating procedures, staffing plans, scripts and standard communications for State approval;
2. Design and maintain paper RV in conjunction with the State;
3. Provide standard payment codes and messages:
   a. Produce HIPAA compliant 835 and 820 transactions;
   b. Accept HIPAA compliant 276 Claim Status requests and return 277 Claim Status Response;

c. Use HIPAA compliant remittance voucher codes and messages for suspended, denied, and paid claims;

d. Apply HIPAA approved explanation of benefit messages; however, the Contractor must submit a solution for making EOB messages more descriptive to the providers;

e. Include provider alert text and other material with remittance vouchers as directed by the State;

f. Produce and transmit electronic or paper remittance vouchers to providers;

g. Report all edit reasons for claim denial on the RV; and

h. Produce messages by provider class, provider type, provider specialty, etc, on remittance vouchers, at the direction of the State.

4. Provide support for provider communications:

a. Provide a Web portal that will allow providers to view or download remittance vouchers with the ability to sort the RV so that they can receive information in a way meaningful to them;

b. Provide technical support to providers submitting or desiring to submit electronic claims to FMMIS/DSS. Provide toll free line(s) and maintain adequate staff to respond to inquiries;

c. Notify providers of any and all hardware requirements;

d. Provide a prompt and accurate response to all inquiries regarding the status of any claim;

e. Provide an automated process for alerting providers, via email, letter, fax, etc, when a credit balance has been setup for a provider;

f. Allow providers the ability to query the FMMIS and see the individual payment history of their recipients via a Web portal;

g. Respond to all verbal provider inquiries on claim status, billing procedures, and remittance vouchers immediately, if possible; if immediate verbal responses are not possible, written responses to verbal inquiries will be made within three (3) workdays of the date of the call;

h. Provide for periodic training of telephone operators. All operators must complete a State approved customer relations training program on a periodic basis as mandated by the State;

i. Review the type (reasons for calls) and initiate enhancements to reduce the number of calls through better automation, and/or training;

j. Provide telephone call message mailbox capability. The Contractor staff shall review and respond to all phone messages within one (1) workday. Phone messages will be logged with the date of the message and date the call is returned, including the provider number, provider name, telephone number and contact person;

k. Log and image all written requests for payment information;

l. Prepare training packages and seminars for new electronic submitters;

m. Ensure that no inaccurate information is given out to providers; and

n. Provide the ability for providers to request and receive, via the Web portal, a paid claims Listing (PCL) for all of their claims in a date range, in formats approved by the State.

5. Monitor quality and work toward continued quality improvement:

   a. Provide information from reviewers independent of the staff performing the Provider Communications Regarding Payment function;

   b. Report on quality compared to previous periods through the Performance Reporting System;

   c. Report specifically on:

      (1) Number of electronic remittances;

      (2) Number of paper remittances;

      (3) Call center activity related to provider payments; and

      (4) Other items as determined by the State.

   d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

   e. Document and implement corrective action plans when requested by the State.

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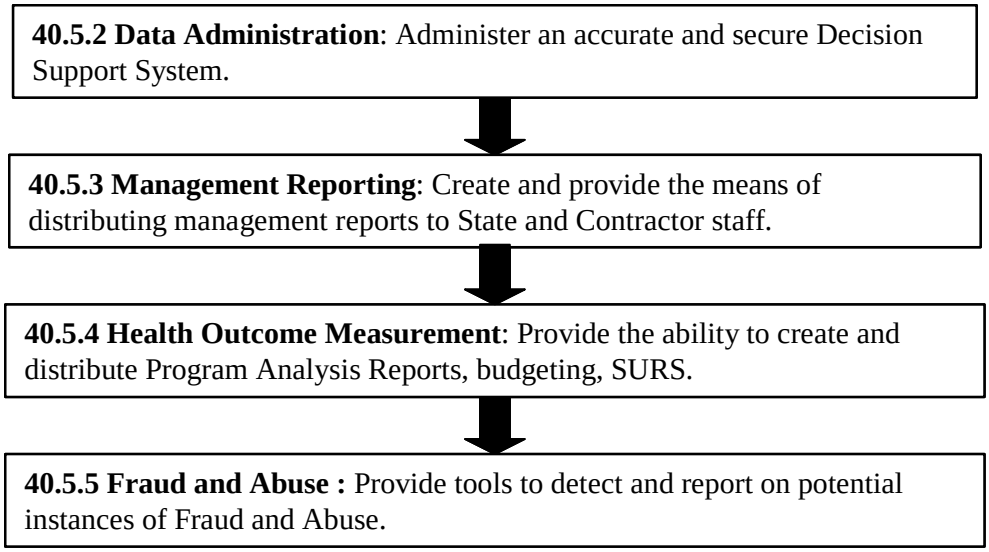
40.5 Health Quality, Program Monitoring and Reporting



40.5.1 Introduction

The Health Quality, Program Monitoring and Reporting Business Processes describe requirements for supporting analysis and evaluation of the State's Medicaid Program and providing information to respond to queries from the State, federal or other entities regarding medical services provided to Medicaid recipients. The Contractor will determine the most efficient means to meet the requirements of this section, whether data is supplied by FMMIS/DSS or other data sources.

40.5.1.1 Overview

The Health Quality, Program Monitoring and Reporting function includes the following business functions:

- Data Administration – This includes the Decision Support System (DSS), which incorporates a data warehouse that stores a variety of data from many disparate sources to support Medicaid and other health care programs and various tools to provide analysis and publication of the data both internally and externally, as applicable;
- Management Reporting – This includes management and administrative reporting and contract management activities to oversee program administration;
- Health Outcome Measurement – This function focuses on the quality and delivery of health care to program recipients. Pharmacy Benefit Management (PBM), Drug Utilization Review (DUR), and managed care reporting are included in this function; and
- Fraud and Abuse Detection and Control – This provides statistical and detailed information on members and providers enrolled in the Medicaid Program. The function features algorithms for isolating potential fraud and inappropriate utilization. An integrated set of reports is produced to support the investigation of that potential misuse.

40.5.1.2 State Objectives

The State's objectives for the Health Quality, Program Monitoring and Reporting Business Processes are to:

1. Have a robust, fast, and flexible foundation of data from which to draw all reports necessary for the effective operation and control of the Florida Medicaid program;
2. Assure that reporting data is as accurate as data used in daily operations and is similarly up-to-date. The State understands the complexity of mirrored data, and will consider aggressive plans to accrete and synchronize data on a daily basis;
3. Allow reporting from the most efficient source possible, including FMMIS/DSS, and other data sources maintained by the Contractor;
4. Provide broad access and tools for State ad-hoc reporting, including libraries of stored queries and training for State users;
5. Monitor the efficiency of Medicaid operations:
    a. Have access to real-time and timely reports on the status of all phases of fiscal agent operations, including manual processes; and
    b. Produce all required federal and State operations reports in a timely, accurate and expedient manner.
6. Monitor the effectiveness of the Medicaid program:
    a. Have access to report production resources and research staff supplied by the Contractor;
    b. Produce all required federal and State service reports in a timely, accurate and expedient manner;
    c. Review provider performance to determine the adequacy and extent of participation and service delivery;
    d. Report recipient participation in order to analyze usage and develop more effective programs;
    e. Monitor the effectiveness of health care delivery systems and models, make forecasts, inform policy decisions and determine in advance the effect of policy changes;
    f. Provide reports to the State about geographical distribution of Medicaid services by county and Agency area;
    g. Monitor expenditures for all Medicaid program services and waivers; and
    h. Provide continuous interrelated statistics to show how the total health care delivery system and its individual parts are meeting program objectives.
7. Detect and control fraud and abuse in the Medicaid program:
    a. Provide a basis for conducting medical/fiscal reviews to verify that covered health care services have been documented and that payments have been made in accordance with State and federal policies, regulations, and statutes;
    b. Provide tools and algorithms for detecting fraud or abuse in the Medicaid program; and

c. Provide tools to track fraud and abuse cases from start to resolution.

40.5.2 Data Administration

40.5.2.1 Data Administration Overview

The State wishes to enhance its Decision Support System (DSS), modernize the technical infrastructure and bring to bear major new capabilities in the area of analytic and normative services.

The DSS must be an accurate and record-wise complete representation of the FMMIS allowing seamless, user-friendly access to the underlying data through the use of several tools.

DSS security must remain paramount, deploying physical, network, database, and application security parameters to prevent unauthorized access to data.

40.5.2.2 Data Administration Inputs

1. FMMIS claims and encounters, recipient, provider, and reference data; and
2. Data from external sources.

40.5.2.3 Data Administration Outputs

1. Custom designed user reports;
2. System usage reports;
3. System update exception control reports; and
4. Data reconciliation reports.

40.5.2.4 Data Administration State Responsibilities

The State will coordinate identification and receipt of data from external sources and approve and/or communicate changes necessary in data extract formats to external sources.

1. Approve design, development, work plans, policies and procedures for all data administration activities:
   a. Designate State staff to be the primary contacts for the Contractor during turnover, implementation and operation of the DSS;
   b. Provide policy and contract clarification as requested by the Contractor;
   c. Conduct a timely review of all materials submitted to the State by the Contractor;
   d. Review and approve all Contractor installed DSS features, including:
      (1) Required data base design descriptions;
      (2) System interfaces;
      (3) Network access approaches;
      (4) Data conversions;

(5) Data mappings; and

(6) Data loads.

e. Test and approve all new installed applications.

2. Provide certain resources for DSS operations:

a. Provide a training laboratory, shared with the State, with eleven (11) workstations to support initial and on-going training of State staff by the Contractor; and

b. Provide on-site office space, surplus office furniture and PC workstations for twelve (12) members of proposed Contractor staff in the State's office complex, currently at 2727 Mahan Drive, Building 3, Tallahassee, Florida.

3. Authorize users of the DSS:

a. Provide approval for user access levels and permissions as identified and agreed upon with the Contractor;

b. Notify the Contractor upon employee termination or if employee access must be changed; and

c. Review DSS security and incident reports.

4. Notify the Contractor of operations problems or issues related to the DSS:

a. Notify the Contractor when a workstation or application is unavailable due to system problems or network connections maintained by the Contractor; and

b. Notify the Contractor if a query does not process in the background or overnight as requested.

40.5.2.5 Data Administration Contractor Responsibilities

1. Install a DSS/Data Warehouse that facilitates the use of modern relational database technologies that will allow for expansion over time, fast processing speeds, and easy maintenance:

a. Incorporate, whenever possible, COTS products that will provide flexibility for data analysis, query tools, and reporting;

b. Provide an Executive Information System (EIS) that is based on rules and parameters of operation that automatically alerts when FMMIS/DSS is operating outside of normal parameters;

c. Maintain mirrored or synchronized data tables for reporting, system monitoring, program analysis, service utilization analysis, management reporting, queries, and quality control; and

d. Store and provide authorized State users with access to up-to-date system documentation, policies and procedures, and user manual(s) related to the data maintained by the Contractor including data, tools, routines, program code, and schemas.

2. Maintain data extraction interfaces and load DSS data using methods and schedules approved by the State:

a. Create and modify extraction programs for interfacing systems to garner, match, and cleanse data;

b. Edit data and apply cleansing rules;

c. Load or synchronize all data at least daily to assure that reporting data is as accurate as data used in daily operations and is similarly up to date;

d. Produce exception reports on all data loads; and

e. Produce data reconciliation reports after each upload indicating total records and sums.

3. Provide for query applications:

a. Allow queries containing multiple claim types simultaneously;

b. Allow users to share queries, routines, and result files;

c. Provide for the migration of existing stored queries; and

d. Assist user in building complex queries.

4. Provide for online reporting capabilities:

a. Dedicate sufficient resources to meet all State reporting needs;

b. Produce standard and scheduled system-generated reports and other State-required information;

c. Provide authorized users with the ability to manipulate system and ad-hoc report results through user-defined parameters;

d. Provide for a certified Surveillance and Utilization Review (SUR) functionality and a certified Management and Administrative Reporting (MAR) capability;

e. Provide risk-adjusted analytical tools to produce reports to assist staff in producing risk-adjusted provider utilization reports for utilization management;

f. Provide the ability to request and produce reports with de-identified recipient data; and

g. Make profiling reports to providers available to providers via a Web portal, allowing them to compare their practice to normative standards.

5. Provide flexible reporting tools:

a. Provide functions that use format, test/fonts, screen grid designs, and illustrations to enhance display;

b. Allow user defined headers, footers, columns, and rows;

c. Provide the ability to segregate and subtotal data;

d. Provide the ability to import, export, and manipulate data files from database management tools;

e. Support statistical analysis capabilities;

f. Maintain and track report production history;

g. Provide capability to include bar charts, pie charts, stacked and side-by-side charts, three dimensional graphs, and other common use graphical presentation methods;

h. Allow customization of the attributes of charts;

i. Support various printing options;

j. Provide for Geographic Information System (GIS) mapping software; and

k. Provide for Soundex Search capabilities.

6. Provide for the overall administration of the DSS/Data Warehouse:

   a. Monitor and maintain system usage information;

   b. Install upgrades and maintenance releases to the system;

   c. Provide for system availability of no less than 98% of the required access and processing times on a weekly basis;

   d. Provide all necessary licenses for the possible growth of 25% over the life of the contract; and

   e. Pay all annual licensing fees for all software.

7. Staff the DSS to meet all reporting requirements:

   a. Provide staff enumerated in Section 50.2;

   b. Provide sufficient staff to administer and maintain the DSS and meet performance standards at no additional charge to the State;

   c. Provide training and ongoing support to the State's security administrator; and

   d. Provide sufficient staff to monitor help-desk functions.

8. During Design and Development Phase, the Contractor must study and analyze all relevant programs and operating procedures in the current FMMIS as it is being operated during the period of Design and Development Phase, including all relevant Customer Service Requests and contract amendments:

   a. Formulate the initial business rules for this business process based on the current FMMIS operations;

   b. Submit the proposed rules to the State for approval;

   c. Enter those rules approved by the State into the Rules Engine;

   d. Test the rules to assure they process as expected, compared to current FMMIS operations; and

   e. During the Readiness Testing Period, demonstrate the accuracy of rules application by proving the comparison to current fiscal agent operations; document and explain any differences to the satisfaction of the State.

9. Monitor quality and work toward continued quality improvement:

   a. Provide information from reviewers independent of the staff performing the Data Administration function;

   b. Report on quality compared to previous periods through the Performance Reporting System;

   c. Report specifically on:

      (1) Data reconciliation activity;

      (2) System usage statistics;

(3) Down time reports; and

(4) Other items as determined by the State.

d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

e. Document and implement corrective action plans when requested by the State.

40.5.3 Management Reporting

40.5.3.1 Management Reporting Overview

The Contractor must operate a system for timely and accurate management reporting to satisfy State and federal requirements, including State requirements for overseeing programs and service delivery. The Contractor's system must replace the functionality of the current Management and Administrative Reporting (MAR) and Contract Management subsystems. The Contractor must make tools available to the State to meet or exceed all federal MAR standards and provide all needed federal and State reports. The Contractor must provide data and reports to give the State real-time understanding of system performance; provide data and reports for the State to use in the financial management of the Medicaid program, including cost allocation; and provide all reports necessary for reporting Medicaid statistics to State and federal regulators, including providing data for MSIS and the CMS-64 Report. The Contractor must provide the State with the resources and tools to analyze system and operations performance.

To provide consistent reporting on the status and quality of fiscal agent operations, the Contractor must develop or use a COTS system to record quality performance standards in every area of operations, to record the acceptable parameters for each standard, to record actual performance (in real time when appropriate), and to notify and report operations that are outside acceptable standards of operation. (As an example, FMMIS/DSS is required to be available at all times, except scheduled downtime. If FMMIS/DSS becomes unavailable for more than 5 minutes, an email is immediately and systematically sent to the Contract Manager and all Medicaid bureau chiefs.)

This Performance Reporting System will be used to calculate Liquidated Damages for performance measures that score 77 or below, but will not be used to calculate performance-based payments to the Contractor. Summary reports from the Performance Reporting System must be posted on the Web portal. Examples of items to be monitored and standards to be applied are in the Report Cards that have been used in the current fiscal agent contract. (See Medicaid Procurement Library)

For formatted reports, the Contractor must develop or use a COTS system to identify and distribute the reports according to State input. This Report Distribution System must allow the State to identify or create reports by specification, dynamically determine the frequency and routing, and determine the output format(s), whether available online, through data download, on CD-ROM, on DVD-ROM, or printed. The Contractor will use the Report Distribution System to automatically generate and distribute all reports from FMMIS/DSS.

40.5.3.2 Management Reporting External Interfaces

1. MSIS (replaces CMS 2082) tape or FTP data files; and
2. Automated CMS 64 Report (If requested)

40.5.3.3 Management Reporting Inputs

1. FMMIS/DSS system operations data;
2. FMMIS/DSS recipient, provider, and claims files;
3. FMMIS/DSS manual operations data;
4. Quality Control monitoring reports and statistics;
5. Provider and Stakeholder survey results;
6. Customer Service Requests (CSR) and CSR status; and
7. Project Status Reports.

40.5.3.4 Management Reporting Outputs

1. System status dashboard available to Medicaid staff via a Web browser;
2. System status reports available online, through data download, on CD-ROM, on DVD-ROM, or printed and distributed as requested by the State;
3. System processing reports to meet MARS requirements available online, through data download, on CD-ROM, on DVD-ROM, or printed and distributed as requested by the State;
4. Financial Management reports to meet MARS requirements available online, through data download, on CD-ROM, on DVD-ROM, or printed and distributed as requested by the State;
5. Management reports available online, through data download, on CD-ROM, on DVD-ROM, or printed; and
6. Report archives. All reports must be maintained on CD-ROM or DVD-ROM for the life of the contract and turned over to the State or successor fiscal agent at the end of the contract.

40.5.3.5 Management Reporting State Responsibilities

1. Approve the design, development, capabilities, structure, methods, and formats of all data and tools to be used in the creation of the Performance Reporting System and the Report Distribution System;
2. Initiate and interpret policy and make administrative decisions;
3. Use the Performance Reporting System, audit methods, sampling, and physical inspection to monitor all fiscal agent operations:
    a. Review all management reports; and
    b. Monitor all Contractor performance (including prime Contractor and subcontractors) and compliance with contract terms and conditions.
4. Determine the frequency, content, format, media, and distribution of production reports and post the information to the Report Distribution System:

a. Serve as a liaison between the Contractor and other components of State and federal government requesting reports; and

b. Coordinate or refer inquiries from other states or private entities as appropriate.

5. Monitor FMMIS/DSS report production:

   a. Determine whether reports are prepared and delivered on schedule; and

   b. Determine the adequacy of records developed by the Contractor to allow for monitoring of all performance requirements and standards.

6. Use reports to account for payments and payment recoveries and to monitor banking activities:

   a. Review automated and manual bank account reconciliations;

   b. Review Contractor invoices and supporting documentation and approve payment;

   c. Monitor provider balances on emergency payments, liens and credit balances and ensure that balances are appropriately cleared; and

   d. Monitor the State's interest-bearing accounts and ensure that interest is returned to the State.

40.5.3.6 Management Reporting Contractor Responsibilities

1. Develop or use a COTS product to create the Performance Reporting System described in Section 40.5.3.1, Management Reporting Overview;
2. Develop or use a COTS product to create the Report Distribution System described in Section 40.5.3.1, Management Reporting Overview;
3. Provide all functionality required to comply with federal Management and Administrative Reporting System (MARS) requirements:

   a. Provide the online ability to configure MARS reports to properly categorize services based on the Benefit Plan structure; and

   b. Meet both existing and new format and data requirements for federal statistical MAR reporting.

4. Produce all reports identified in the Report Distribution according to the schedule, in the media, and to the distribution list set by the State:

   a. Ensure all reports are complete and accurate prior to distribution; and

   b. Submit the federal MSIS report in the format and protocol set by the State.

5. Provide an online dashboard with common Medicaid and production statistics, fed from the Performance Reporting System:

   a. Include an online screen containing up-to-date summary information on the number and categories of providers, recipients, and services, updated monthly; and

   b. Show claims throughput activity, claims backlog, key entry backlog, pend file status, and other performance items determined by the State.

6. Provide User training to State and Contractor staff:

a. Provide all necessary user training, including but not limited to training manuals, system and data documentation, and/or online help screens that provide access to the Performance Reporting System; and

b. Provide all necessary user training, including but not limited to training manuals, system and data documentation, and/or online help screens that provide access to reports in the Report Distribution System.

7. Monitor and make recommendations to the State to improve or enhance the functionality of the Management Reporting business area and edit/audit capabilities;

8. Provide the State Contract Management Office staff with unlimited access to monitor and observe all Contractor and subcontractor functions;

9. Produce standard financial management reports based on the schedule, format and distribution set in the set in the Report Distribution System:

   a. Produce weekly report of provider payments, including special payments;

   b. Produce weekly report of receivables for each provider (negative balances) showing increases/decreases and cumulative year-to-date figures after each claims processing run;

   c. Produce systematic reports on liens and providers with credit balances;

   d. Produce invoices and supporting documentation for administrative payments to the Contractor; and

   e. Produce FMMIS/DSS bank reconciliation report on a monthly basis, preferably using an automated process or COTS product.

9. Generate expenditure, eligibility, enrollment and utilization data by Benefit Plan to support budget forecasts, monitoring and health care program modeling;

10. Generate reports on changes to benefit plans, costs and other reports specified by the State; and

11. Monitor quality and work toward continued quality improvement:

    a. Provide information from reviewers independent of the staff performing the Management Reporting Data Administration function;

    b. Report on quality compared to previous periods through the Performance Reporting System;

    c. Report specifically on:

       (1) Data reconciliation activity;

       (2) System usage statistics;

       (3) Down time reports; and

       (4) Other items as determined by the State.

    d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

    e. Document and implement corrective action plans when requested by the State.

40.5.4 Health Outcome Measurement

40.5.4.1 Health Outcome Measurement Overview

Various quality assurance and analytical services are performed across the Medicaid program. Health outcome measurements are obtained through analysis of claims data obtained from a broad spectrum of Medicaid providers. Health outcome data is most commonly obtained for analysis of the effectiveness of programs such as Retroactive Drug Utilization Review (RetroDUR), Disease Management, and Managed Care Programs. The purpose for Health Outcome Measurement functionality is to:

1. Provide the State with the ability to monitor the effectiveness of the Medicaid program on health outcomes;
2. Provide trend analysis and exception reports to identify improperly utilized drugs or procedures;
3. Provide analysis tools and reports necessary to conduct Peer Reviews;
4. Provide tools and data for Medicaid program analysis and other data users in monitoring and research and to assist the State in setting Medicaid policies;
5. Provide tools and reports to measure and compare the ongoing Quality of Care, based on services and health outcomes;
6. Provide tools and reports for the Medicaid program to compare the effectiveness of alternate Benefit Plans, including HMO, MediPass, Provider Service Networks, Alternate Service Networks, waiver programs, long-term care alternatives and fee-for-service, taking into consideration geographic location, population demographics and severity of condition; and
7. Provide tools and reports for the State to use in strategic planning and State plan administration.

Health Outcome Measurement supports the Pharmacy Benefits Management (PBM), Retroactive Drug Utilization Review (RetroDUR), and Managed Care Reporting business functions. Managed Care encompasses HMO, MediPass (PSN, ASN, integrated therapies, EPO, when in place, DMO, PACE, and Pediatric Diversion programs), and other waiver healthcare services.

Health Outcome Measurement must support analysis of the State's current and future Disease Management Organizations (DMO). AHCA has contracted with disease management organizations to provide disease management services to Medicaid recipients enrolled in the Primary Care Case Management Program (MediPass) who have been diagnosed with diabetes HIV/AIDS, asthma, hemophilia, congestive heart failure or end stage renal disease. DMO services may be implemented for MediPass recipients who have been diagnosed with sickle cell anemia, cancer, or hypertension. DMO services are also provided to children who are enrolled in the Children's Medical Services (CMS) Network, attend prescribed pediatric extended care centers, or reside in institutional settings. FMMIS/DSS must be able to measure and compare outcomes of patients with DMO services to those not receiving DMO services, to the general population and to similar clients in our State or in other states' health care programs outside of Medicaid. Measurement and outcome reporting must include both medical and economic (cost) comparisons.

40.5.4.2 Health Outcome Measurement External Interfaces

1. Database(s) of standardized health data such as Minimum Data Set (MDS);
2. First DataBank;
3. Disease Management Organizations (DMO);
4. Managed Care Organizations (MCO);
5. Prepaid mental health and dental plans;
6. Pharmacy Benefits Manager (PBM); and
7. Other sources as designated by the State.

40.5.4.3 Health Outcome Measurement Inputs

1. FMMIS/DSS provider, recipient and claim and encounter data.

40.5.4.4 Health Outcome Measurement Outputs

1. Data extracts for policy analysis; and
2. Reports for policy analysis and payment calculations.

40.5.4.5 Health Outcome Measurement State Responsibilities

1. Determine and communicate all State requirements, policies and procedures;
2. Determine and communicate desired report content and file layouts for data extracts;
3. Use reports supplied by the Contractor or developed by the State for Health Outcome Measurement to calculate fees based on health outcomes or program savings as a result of efficient service administration;
4. Use reports supplied by the Contractor or developed by the State for Health Outcome Measurement to identify new recipient groups recommended for disease management;
5. Use reports supplied by the Contractor or developed by the State for Health Outcome Measurement to identify new systems of care delivery that may improve health outcomes or system cost efficiency; and
6. Use reports supplied by the Contractor or developed by the State for Health Outcome Measurement to set Medicaid policy.

40.5.4.6 Health Outcome Measurement Contractor Responsibilities

1. Maintain reference files from external sources to use in creating health outcome comparisons or analysis:
   a. Maintain reference files of national health care information for comparison to Florida Medicaid health services delivery and outcomes. The Contractor must propose sources and descriptions for these files and describe methods of comparison to help the State develop and document recommendations to improve the efficiency and efficacy of services under the Medicaid program;
   b. Maintain a Preferred Drug List (PDL) as directed by the State. The PDL updates must be by date sensitive segments.

c. Make the PDL, 90 days of pharmacy history, e-prescribing and the DUR pharmacology database available to all providers via the web site;

d. Make the PDL, 90 days of pharmacy history, e-prescribing and the DUR pharmacology database available to a segment of users via Personal Digital Assistant (PDA) distributed by the Contractor; and

e. Use professional pharmacy staff, the Preferred Drug List (PDL), and national normative data to provide appropriate and economical prescribing practice information to pharmacies, physicians, and other providers. Create an aggressive program to identify targets for this information during ProDUR, processing of exceptions to drug coverage and limitations, and from service utilization and other reports. Provide comparative reports for pharmacies, physicians and other providers to access via the Web portal to view a comparison of their practice to normative standards, with recommendations for improvement. Report monthly on the comparative effectiveness of this education and information.

2. Provide a system with the ability to monitor the effectiveness of the Medicaid program on health outcomes:

a. Provide system functionality to analyze, compare and measure all claim types;

b. Provide the ability to track payments for each recipient in total, and to limit payments to any combination of Benefit Plans based on total services or an overall dollar ceiling, as set by rules in the Benefit Plan Administration Rules Engine;

c. Provide state-of-the-art diagnosis to procedure functionality;

d. Provide the capability to compare a provider to other providers of the same type and specialty;

e. Provide for managed care to fee-for-service analysis;

f. Provide for Benefit Plan comparisons;

g. Provide the capability to perform data analysis functions State wide or by geographical area for services provided through the Florida Medicaid program;

h. Provide trend analysis and exception reporting capabilities to identify improperly utilized drugs or procedures, with an emphasis on the impact of improper utilization to health outcome;

i. Provide analysis tools and reports necessary to compare providers to each other, individually or by groupings, to determine parameters of most efficient and effective care;

j. Provide analysis tools and reports that have the functionality to compare encounter claims and fee-for-service claims for the same or like services provided and to report on the services over flexible time spans;

k. Provide analysis tools and reports that have the functionality to compare overall managed care expenditures and overall fee-for-service expenditures for same or like charges and same or like services, and report on the charges over flexible time spans, state-wide, or by geographical areas;

l. Provide analysis tools and reports that have the functionality to compare providers by specialties and/or subspecialties that submit encounter claims and providers by specialties and/or subspecialties submitting fee-for-service claims for the same or like charges; monitor the charges over flexible time spans;

m. Provide analysis tools and reports that have the functionality to compare providers that submit encounter claims and providers submitting fee-for-service claims by State defined diagnoses; report on the diagnoses treatment outcome results over flexible time spans to determine those providers providing the most favorable medical outcome including morbidity rate; and

n. Provide analysis tools and reports that can provide trend analysis by type of service and target program services that show over or under utilization of services or program type, e.g. ambulance services, mental health services or home healthcare services. Trend analysis will assist the State in determining program rules and medical policy rules to assist in guaranteeing that recipients receive high quality and medically necessary services. Trend analysis will also assist the State and Contractor in identifying ineffective service programs or providers that are taking advantage of Medicaid programs.

3. Provide a Therapeutic Consultation Call Center (TCCC) function to advise drug prescribers on best practices for recipients with multiple prescriptions:

   a. Staff the TCCC with clinical pharmacists and pharmacy technicians who are up to date on diseases and conditions that affect the Florida Medicaid population and therapy options for each. Maintain sufficient staff to answer 90% of call within two (2) minutes;

   b. Operate the TCCC from 8:00 a. m. to 8:00 p. m. Monday through Friday and from 10:00 a. m. to 2:00 p. m. on Saturdays;

   c. Review the entire drug profile for recipients who are prescribed drugs in excess of limits established by the State. Discuss with the prescriber the most cost effective therapies and other appropriate drug therapies;

   d. Record the resolution of all calls and maintain data and records for analysis; and

   e. Mail State-approved educational materials to providers that do not comply with the TCCC recommendations.

4. Provide 325 on-site visits to prescribers each month by registered pharmacists who report to AHCA Medicaid Pharmacy Services to provide educational materials to providers and academic detailing information;

5. Use professional pharmacy staff, the Preferred Drug List (PDL), and national normative data to provide academic detailing information to pharmacies, physicians, and other providers. Create an aggressive program to identify targets for this information during ProDUR, processing exceptions to drug coverage and limitations, and from service utilization and other reports. Report monthly on the comparative effectiveness of the academic detailing information;

6. Provide the ability to track individual compliance with certain specified health care treatments, such as immunizations, prenatal visits, disease management

care plans; and to enroll or disenroll a recipient in a Benefit Plan based upon compliance or lack of compliance;

7. Provide routine comprehensive analysis of the quality and completeness of MCO encounter data to assure the Agency is receiving valid and reliable information on the financial costs and quality of care from its MCO providers:
   a. Analyze the encounter data from each MCO on a priority schedule prepared by the Agency and delivered to the Contractor;
   b. Prepare comprehensive reports for each MCO on the schedule that identify the level of completeness of the data, discrepancies in the data, and other factors that impact the quality, accuracy and reliability of the data;
   c. Meet with each MCO and Agency representatives at the MCO site to discuss and resolve data validation issues;
   d. Create and implement corrective action plans when necessary or when directed by the Agency, and assist the MCOs in the creation and implementation of corrective action plans; and
   e. Use nationally recognized analytical protocols and statistical software models for comprehensive review of FMMIS encounter data quality and completeness. The State encourages the Contractor to employ the services of a nationally recognized company with experience and expertise in the field.
8. Monitor quality and work toward continued quality improvement:
   a. Provide information from reviewers independent of the staff performing the Health Outcome Management function;
   b. Report on quality compared to previous periods through the Performance Reporting System;
   c. Report specifically on:
      (1) Update/receipt of external data sources; and
      (2) Other items as determined by the State.
   d. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and
   e. Document and implement corrective action plans when requested by the State.

40.5.5 Fraud and Abuse Detection

40.5.5.1 Fraud and Abuse Detection Overview

The Fraud and Abuse Detection (FAD) function includes those processes necessary for the protection and monitoring of Medicaid and related programs to detect provider and recipient over-utilization or improper utilization of services and fraudulent billing practices.

The objective for Fraud and Abuse Detection is to:

- Provide tools and reports to the State to meet or exceed all federal SURS (Surveillance and Utilization Review System) standards;

- Provide tools and reports to the State to effectively identify and prevent Medicaid program fraud and abuse;
- Provide tools for pharmacy audits;
- Support sampling and overpayment determination techniques used by Medicaid Program Integrity;
- Support Medicaid Program Integrity and Medicaid Fraud Control Unit (MFCU);
- Provide fraud and abuse case tracking functionality; and
- Conduct Retrospective Drug Utilization Review (RetroDur).

40.5.5.2 Fraud and Abuse Detection External Interfaces

1. External Quality Review Organization (EQRO);
2. Attorney General's Office, Medicaid Fraud Control Unit (MFCU); and
3. Department of Administrative Hearings (DOAH).

40.5.5.3 Fraud and Abuse Detection Inputs

1. FMMIS/DSS recipient, provider, claim, encounter and reference data;
2. FMMIS/DSS Service Authorizations;
3. Retrospective DUR criteria entered or approved by the State;
4. Medical records data;
5. Normative benchmarks;
6. Case tracking updates; and
7. Case tracking document images.

40.5.5.4 Fraud and Abuse Detection Outputs

1. Drug Utilization Reports;
2. Fraud and Abuse Reports; and
3. Lock-in Reports.

40.5.5.5 Fraud and Abuse Detection State Responsibilities

1. Approve the design of a fraud and abuse case tracking system developed by the Contractor and control access:
    a. Authorize access to the online case tracking system for fraud and abuse investigations and related reports;
    b. Establish policy and make or delegate all administrative decisions concerning the operation of, and any changes to the Fraud and Abuse Detection (FAD) reporting function;
    c. Define the desired content, format, frequency and media for reports; and
    d. Initiate and execute online changes to FAD management files as needed.
2. Approve criteria used by the Contractor to detect fraud and abuse:

a. Assist the Contractor in defining the statistical parameters which the fraud and abuse profiling system will use to detect patterns of fraud, abuse, and other aberrant claims;

b. Determine criteria for claims and encounter extracts and sampling for fraud and abuse profiling;

c. Specify the data elements necessary to define provider and recipient peer groups for fraud and abuse profiling, and other selected criteria such as diagnosis, drug therapeutic class, and procedure codes;

d. Specify the parameters necessary to produce provider and recipient patterns that are inconsistent with sound fiscal, business or medical practices and which result in unnecessary costs to the Medicaid program or reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards of health care;

e. Review and approve parameters for the production of RetroDUR reports; and

f. Approve the weighting and ranking method which set priorities for reviewing utilization review exceptions.

3. Request, receive, review, investigate and route fraud referral information from the Contractor and external sources:

a. Act as a liaison between the Contractor and other entities that may request or receive fraud and abuse related information or statistics, including the MFCU;

b. Perform analyses and reviews of providers identified by fraud and abuse profiling as having aberrant billing, service, or usage patterns; and

c. Use FMMIS/DSS data to conduct on-site, full-scale investigations and audits of provider and/or recipient abuse or fraud of the Florida Medicaid program to document noncompliance with regulations or laws, intentional misrepresentation of services, the occurrence of unnecessary or inappropriate services, or defects in the quality of care.

4. Use the case tracking system to document referral review activity in the case tracking system including follow-up, audit, MFCU referral, settlement agreements, and recoupment activities to support the future fraud and abuse investigation activity;

5. Make decisions restricting providers or recipients based on results from fraud cases or investigations:

a. Review results from automated fraud and abuse profiling system;

b. Identify providers to be placed on prepayment review;

c. Refer recipients to appropriate utilization programs for restriction and/or monitoring (lock-in); and

d. Monitor restricted recipients and providers, and determine when to remove restrictions.

40.5.5.6 Fraud and Abuse Detection Contractor Responsibilities

1. Implement, maintain, and operate a highly adaptable Fraud and Abuse Detection (FAD) system for the ongoing, retrospective, comprehensive analysis of

FMMIS/DSS data for the detection of potential provider and recipient Medicaid program fraud, abuse, or improper utilization. The FAD system must:

a. Accommodate complex decision algorithm analysis;

b. Produce graphical reports and charts;

c. Allow user to run fraud studies using flexible, user-defined time periods;

d. Provide the ability to run fraud studies on-demand, from the user's desktop, without dependence on mainframe scheduling or competition for resources;

e. Allow data to be selected in unlimited combinations to create broad-based or narrowly-focused peer groups;

f. Provide the functionality for aggregations to be performed on any appropriate data element;

g. Allow fraud studies to be created by the State or Contractor staff, archiving the results and saving the study for re-use;

h. Develop pre-defined templates and/or algorithms and provide the capability for a user to initiate customized pattern recognition queries;

i. Maintain a process to apply weighting and ranking to exception report items to facilitate identification of deviation or exceptions;

j. Perform iterative analysis, allowing for multiple real-time analysis review cycles; and

k. Allow specific inclusion or exclusion of provider, provider organization, recipient, enrollee, billing agent, or other population in the detection process.

2. Design and implement activities to proficiently and proactively detect:

   a. Potential fraud and abuse by all providers and recipients;

   b. Inappropriate billings and over payments, and violations of provider instructions conveyed by applicable Medicaid handbooks and bulletins; and

   c. Significant percentage increase or decrease in provider's claim.

3. Perform detection and normative benchmarking of use, cost, and treatment patterns using:

   a. Clinically and analytically defensible provider grouping and profiling methodologies;

   b. Normative benchmarks;

   c. Review criteria and standards; and

   d. Clinical and financial indicators and measures.

4. Perform detection of potential fraud or abuse by using appropriate statistical comparisons:

   a. Provide a proven statistical methodology to classify recipients into peer groups using user-defined criteria such as age, sex, race, ethnicity, living arrangement, geographic region, program, aid category, and special program indicator (or any combination thereof) for purpose of developing statistical profiles;

b. Provide a proven statistical methodology to classify private/public providers into peer groups using user defined criteria such as program, category of service, provider type, multiple specialties, multiple sub-specialties, type of practice/organization, enrollment status, facility type, geographic location, billing versus performing providers, and size or any combinations thereof, for the purpose of developing statistical profiles;

c. Provide a proven statistical methodology to classify and reclassify treatment into user defined groups, by diagnosis code, drug code, procedure code, episode of care, groups or ranges of codes, geographical region, or combination thereof, for the purpose of developing statistical profiles;

d. Generate random sampling using a State-approved methodology, including stratified random sampling, with associated statistics (for example: universe statistics and confidence levels). Document the random sampling methodology for use in court hearings. Provide the option to preserve the random seed to reproduce the random sample or to generate a new seed to produce a new random sample;

e. Generate statistical norms and statistical samples, by peer or treatment group, for each indicator contained within each statistical profile by using averages and standard deviations or percentiles; and

f. Extrapolate sample results using generally accepted statistical techniques; this capability must include the ability to extrapolate, at various levels of confidence, instances of attributes or occurrences in the sample (number of claims with errors) and value of variables in the sample (dollar overpayments).

5. Perform detection of fraud or abuse by comparing claims to parameters approved by the State:

a. Maintain online parameter-driven multiple control files which allow the State to specify data extraction criteria, report content, parameters, and weighting factors necessary to properly identify aberrant situations;

b. Develop, design, modify, and test alternative report parameters and maintain an indexed library of such report parameters;

c. Edit all parameters for presence, format, and consistency with other data in Fraud and Abuse Detection, including the following processes:

(1) Perform pattern analysis of illogical or inappropriate billing across claims type and healthcare setting;

(2) Identify unmatched complementary services or diagnoses reported within the user defined timeframes;

(3) Associate all referred services to the referring/admitting/prescribing provider;

(4) Provide the capability to analyze care being depicted as an episode of care, a global view of a recipient's treatment over time across all settings;

(5) Cross-reference multiple providers services rendered to one recipient on the same date of service;

(6) Associate services furnished in a clinic setting to both the clinic and the servicing provider;

(7) Provide for claims data selection, including all adjustments, by date of payment and date of service, for report generation purposes; and

(8) Analyze treatment patterns across different claim types, such as, physician office visits and pharmacy prescriptions to hospital stays, ambulance trips, and equipment rentals.

6. Analyze the drug usage of Medicaid recipients and review the dispensing patterns of pharmacies and prescribing physicians. Produce reports identifying aberrant usage or prescribing practices;
7. Design, develop and implement standard, preformatted reports that obtain and present data related to recipient and provider claim history (paid and unpaid) and summarization of services by clinical categories:
   a. Reports must allow the user to identify provider or recipient IDs and date of service range, based on ad-hoc requests;
   b. Reports must be available at summary and detail level with multiple select and sort formats, layouts, frequency and media to be defined by the State, including:
      (1) Reports related to Fraud and Abuse Detection;
      (2) Ranking reports;
      (3) Exception reports;
      (4) Control file reports; and
      (5) Management reports.
   c. Codes shown on reports should include a description, including codes for procedures, drug, and diagnosis codes, CLIA certification codes, specialty, sub-specialty, and any other codes on all reports;
   d. Reports must be available online, and allow authorized users to sort, group, regroup, summarize, window by time, print, export to PC software, and perform other output management functions, including drill-down to the original claims data for a more detailed view;
   e. Reports must provide the drill down capability from online reports to analyze underlying data; and
   f. Reports must meet the guidelines for compliance with federal SURS requirements.
8. Using templates of previous reports and suggestions from the State during the Design and Development Phase, create a library of reports for the State to use from the beginning of the Operations Phase. Examples may include:
   a. Waiver lengths of stay, including lengths of stay in hospitals and nursing homes while in the waiver group;
   b. Hospital stays, including length of stay, room and board charges, ancillary charges, and medical expenses prior to and immediately following the

hospital stay by program and medical coverage group for waiver and non-waiver recipients;

c. Ancillary, ambulatory, and inpatient services provided to LTC residents, while resident in, or on leave days from, a facility based on living arrangement;

d. Physician detail reports, by provider number, which identify the number of visits to various types of facilities by performing providers, and give details for recipients, including date of service, procedure code, and amount billed;

e. Comprehensive recipient and provider profiles using peer grouping methodology, calculating class group averages and standard deviations to determine outliers, and ranking providers and recipients by total exception weight;

f. Provider profiling and Fraud and Abuse Detection reports based on:

(1) Rendering provider;

(2) Pay-to provider;

(3) Referring provider;

(4) Health plan;

(5) Primary care Provider;

(6) Group provider number;

(7) National Provider identifier (NPI), when implemented;

(8) Prescribing provider;

(9) Group billers and MCOs, and identified rendering providers separately, based on group providers claims;

(10) Billing services or other non-traditional providers; and

(11) Prescribed or referred by a physician or case manager/PCP in the referring providers' profile.

g. Recipient profiling and Fraud and Abuse Detection reports based on:

(1) Original recipient ID;

(2) Recipient case number;

(3) Enrollment waiver program;

(4) Enrollment health plan;

(5) Enrollment primary care provider (PCP);

(6) Eligibility programs/benefit packages; and

(7) Waiver service.

9. Conduct comprehensive and systematic ongoing review of Medicaid program utilization, as well as targeted or focused reviews, profiles, and specialized analyses and decision support services as may be requested by the State;

10. Provide technical assistance as needed to assist the State users in researching problems, reviewing reports, establishing report parameters, and analyzing Fraud and Abuse Detection data;

11. Participate in the analysis of RetroDUR reports in conjunction with State pharmacist staff;
12. Develop or use a COTS Fraud and Abuse Case Tracking System with the capability to:
    a. Allow the State to define all the work steps for different kinds of cases;
    b. Automatically assign a unique identification number for each case and allow for manual assignment of unique identification numbers;
    c. Automatically assign and/or re-assign cases to a unit and an analyst based on user-defined criteria, including workload balancing;
    d. Manually reassign cases;
    e. Route and record all work done on a case, whether by State, Contractor staff or consultants;
    f. Schedule events related to the case, such as hearings and legal proceedings, and provide notices to State staff in various agencies;
    g. Provide the capability to image all case-related documents, including responses received from providers, recipients and other entities involved in the case and attach these imaged documents to the case to which they pertain;
    h. Request information from the provider under review, or from a sample of recipients for whom Medicaid claims were paid to the provider, and/or from external entities who can supply information needed to complete the review;
    i. Link all documentation (imaged documents, reports, letter, and spreadsheets) to the case using the unique identifier, and retain all pertinent electronic and imaged documentary evidence for referral and recovery when criminal or administrative sanctions appear warranted;
    j. Allow upload and download of case tracking information and documents by an authorized user;
    k. Find, view, and update review and recovery case records;
    l. Add or delete claims that are included in any case created;
    m. Maintain free form notes regarding the case;
    n. Record appeals, including the date an appeal was filed, the type of appeal, filer, date of appeals notification, and the decision;
    o. Record settlement agreements on the case and the status and status dates of progress in the settlement;
    p. Allow State users or automated rules set by the State to lock-in a recipient to a certain pharmacy or other provider for certain services, and deny all claims in a category for that recipient from other providers; and
    q. Analyze staff workload and performance, such as:
        (1) Number of cases reviewed;
        (2) Number of claims included in the universe;
        (3) The number of actual claims reviewed in the sample;

(4) Total dollars reimbursed for cases included in the universe;

(5) Total dollars reimbursed for actual claims reviewed in the sample;

(6) Total dollars identified as overpayments for claims reviewed included in sample size; and

(7) Reports by quarter, calendar year or fiscal year by individual reviewer or collectively for the entire unit.

13. Assist the State in a transition from its existing case tracking system to FMMIS/DSS Fraud and Abuse Case Tracking System;

14. Attend annual fraud and abuse conferences, at the Contractor's expense, and bring back information on the most current methods and technologies to the State. The Contractor must produce a white paper of the conference highlights and provide this paper to the State within fourteen (14) calendar days of the conference;

15. Recommend all additional fraud and abuse methods, algorithms, actions, activities, theories, tools, and techniques of which the Contractor becomes aware; and

16. Monitor quality and work toward continued quality improvement:

    a. Provide information from reviewers independent of the staff performing the Health Outcome Management function;

    b. Report on quality compared to previous periods through the Performance Reporting System;

    c. Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

    d. Document and implement corrective action plans when requested by the State.

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50 SCOPE OF WORK

In broad terms, this section of the RFP describes when, who, where, and how the Contractor must meet the business and technical requirements of the contract. To be more specific, it addresses requirements for project phases; staffing; location of work; project planning and management; and deliverable procedures.

The Contractor must design, develop, implement and operate a Medicaid Management Information System (MMIS) and Decision Support System (DSS) new to the State of Florida and take over all fiscal agent operations from the incumbent fiscal agent (or continue operations using the new system, if the incumbent and the Contractor are the same) on or about July 1, 2007. For purposes of this contract, FMMIS/DSS shall mean the MMIS and DSS designed, developed and implemented by the Contractor to meet all of the business requirements contained in this RFP.

50.1 Contract Phases

Within the parameters of the phases described below, the Contractor must develop detailed plans to develop, design and implement FMMIS/DSS and to take over all operations from the current fiscal agent by July 1, 2007. There are specific requirements for each phase. Phases may overlap in their time schedules.

The Contract Phases are:

1. Design and Development;
2. Implementation Planning;
3. Implementation;
4. Operations;
5. MMIS Certification;
6. Electronic Health Records Development;
7. MITA Gap Analysis; and
8. Turnover.

The detailed plan and schedule must consider phased deployment of business functions to reduce risk. The Contractor should consider such functions as provider enrollment, production of manuals and handbooks, creation of the Web portal, online eligibility verification, infrastructure creation, quality assurance processes, performance reporting and paper claims data entry as possible candidates for early deployment. Deployment of core functions, such as claims adjudication, Pharmacy Point of Service (POS) processing, and the Decision Support System are planned to occur exactly on July 1, 2007. Some non-critical business functions may be candidates for deployment shortly after July 1, 2007.

The State requires a Readiness Testing Period of at least five months for parallel, user acceptance and limited beta provider testing after FMMIS/DSS is ready for deployment, including all critical business functions. All data to date must be converted from the incumbent before this testing period begins. Testing must be completed by July 1, 2007.

Implementation by July 1, 2007 is of critical importance to the State. The Vendor must describe in detail its approach to assure assumption of fiscal agent responsibilities without

disruption to recipient care or provider payments. The five-month Readiness Testing Period is a firm requirement. Otherwise, the State will approve a schedule that implements new requirements over time.

The following factors are in order of importance to the State:

- Assumption of operations without disruption in services or payments;
- Assumption of operations by July 1, 2007;
- Maintaining and achieving federal MMIS certification;
- Ability to process all requirements of Florida Medicaid Reform;
- Compliance with all HIPAA requirements;
- Timely design and development of new components affecting providers (Web portal, Web-based claims submission);
- Design and development of components that improve efficiency and convenience for State staff; and
- Design and development of components that improve Contractor efficiency.

50.1.1 Design and Development Phase

Upon receipt of the Authorization to Begin Work, the Contractor will begin the Design and Development Phase. During this phase, the Contractor will transfer to Florida, or develop new for Florida, a Florida Medicaid Management Information System and Decision Support System (FMMIS/DSS) that complies with the requirements of this RFP. The Contractor must make or alter FMMIS/DSS to meet the business functional requirements described in Section 40. The Design and Development Phase will end upon successful installation of FMMIS/DSS, State acceptance, start of operations and resolution of startup issues. The scheduled end of this phase will be on or about October 1, 2007.

50.1.1.1 Planning

The Contractor must conduct all planning activities associated with the design and development of FMMIS/DSS as defined in Section 50.4 for Large Projects. The Contractor must create a schedule for design and development and submit the schedule for State approval. A draft schedule must be included in response to this RFP.

50.1.1.2 Requirements Analysis

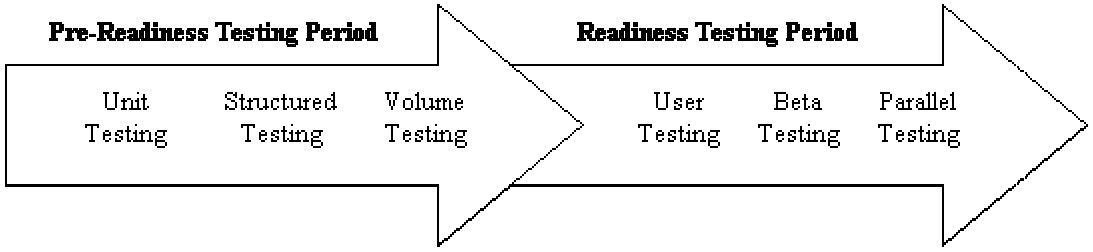
The Contractor must conduct a thorough Requirements Analysis using steps and producing deliverables as required for Large Projects under Section 50.4. State stakeholders must be identified by the Contractor, and will be active participants in the process. The Contractor must also produce Requirements Analysis documentation, in formats approved by the State.

50.1.1.3 Business and Technical Design

After the Requirements Analysis is complete, the Contractor must establish and maintain the system design using an Information Systems Development Methodology (ISDM) appropriate to the development platforms used by the Contractor and approved by the State. The Contractor must produce system design artifacts that support scope definition and facilitate traceability of requirements from requirements analysis through to the system documentation defined in Section 40.1.3.12.

50.1.1.4 Comprehensive Testing Plan for Design and Development

The Contractor must create and deliver to the State comprehensive and thorough testing plans before technical design is complete. This testing plan must incorporate Unit, Structured and Volume testing which occur prior to the Readiness Testing Period and User, Beta and Parallel Testing, which are components of the Readiness Testing Period as illustrated in the diagram below.



Unit Tests

Testing must include bench or unit tests to ensure that changes meet the intended purpose, do not cause unintended consequences (regression testing), and do not cause system errors upon execution of changed programs, batches, pages, or procedures.

Structured Data Tests

The Contractor will create test scenarios or use cases before construction with anticipated outcome for each scenario. When structured data tests are run, the Contractor must present a report on the structured data test to the State, including the anticipated and actual outcomes. The Contractor must include any scenarios submitted by the State. All discrepancies must be identified and explained.

Volume Tests

The Contractor must aggressively test for production based on estimates of transaction volume supplied by the State. The Contractor must use volume simulating tools and methods, and must include a description of its volume testing plan and schedule in response to this RFP.

Operations Readiness Tests

The Contractor must prove to the State that it is ready to begin operations using FMMIS/DSS. This testing must include demonstrations, load testing and results, staff readiness testing, and communications testing. The Contractor must include a description of its operations readiness testing strategy, methodology and schedule in response to this RFP.

Parallel Tests

The Contractor must plan parallel tests of FMMIS/DSS based on actual converted data that can be compared to current operations of the FMMIS. These must be real tests on actual converted data; therefore, data conversion must be complete through the testing date before parallel testing can begin. The State requires at least five months of parallel testing, to ensure that all functions are working properly. The Contractor must include a description of its parallel testing strategy, methodology

and schedule in response to this RFP. Parallel Testing is a part of the Readiness Testing Period.

Beta Tests

For system components that affect external users, such as Web portals, Web-based claims submission, claims software, and data entry by other contractors, the Contractor must have a Beta testing plan, allowing external users to participate in the testing process. The Contractor must describe its approach to Beta testing in response to this RFP. Beta Testing is a part of the Readiness Testing Period.

User Acceptance Tests

System acceptance depends on a final, disciplined set of tests by the State for User Acceptance Testing. The Contractor will draft a design and schedule for user acceptance tests early in the development of test plans. The State will review, modify and approve the User Acceptance Testing plan to make sure all State concerns are addressed. The Contractor must describe its approach to User Acceptance Testing in response to this RFP. User Acceptance Testing is a part of the Readiness Testing Period.

Retesting

The Contractor must have a reasonable and aggressive plan to deal with the situation when tests fail. The Contractor is responsible to meet the overall deadlines for this implementation; therefore, the Contractor must include a description of its strategy and methodology for dealing with the situation where unit tests, structured data tests, operation readiness tests or parallel tests fail to produce the desired results in response to this RFP.

50.1.1.5 Risk Analysis and Contingency Planning

The size of this project represents significant risk to the State. The Contractor must conduct all risk management activities associated with the design and development of FMMIS/DSS as defined in Section 50.4 for Large Projects. The State will place special scoring emphasis on the Contractors control and management of project risks in this phase of the project.

50.1.1.6 Technical Design and Construction

The Contractor must use and apply professional standards and methodologies consistent with the requirements of Section 50.4.1.2 in the design and development of FMMIS/DSS. The systems development methodology to be used by the Contractor is subject to State approval at the outset of the Design and Development Phase.

50.1.1.7 Testing

The Contractor must execute the Comprehensive Testing Plan for this project phase.

50.1.1.8 Training for State and Contractor staff

1. The Contractor must develop training plans, materials and schedules according to the requirements of Section 40.1.3.15, Provider Training Requirements, for all components of FMMIS/DSS, subject to State approval; and

2. The Contractor must provide training in FMMIS/DSS for all users, including Contractor staff and State staff, prior to implementation.

50.1.1.9 State Acceptance Testing

The State will review test results, with a special focus on structured data tests, parallel tests, and retests of failed items. The State will not approve FMMIS/DSS components for implementation until all tests for a component pass to the satisfaction of the State. The Contractor must revise and retest as often as necessary to meet State requirements.

50.1.1.10 State Responsibilities for Design and Development Phase

1. Provide an Implementation Team of up to twelve (12) individuals with duties that include working with the Contractor on the design and development of FMMIS/DSS;
2. Participate in Joint Application Design (JAD) sessions to ensure that the Contractor has adequate understanding of the State role, Contractor role and system requirements for each business function;
3. Review all prototypes, screen designs, architecture designs, work plans, requirements documents, and all deliverables defined in Section 50.4 for Large Projects and provide quick response and comment. The standard turnaround for State review shall be five to seven work days. The State encourages early submission of draft documents to expedite State review;
4. The Implementation Team must transmit final documents and deliverables that are subject to review by Agency officials, other State officials or federal officials to them for review, and deliver results of any such review to the Contractor; and
5. Approve FMMIS/DSS for operations upon successful conclusion of all activities described in this phase.

50.1.1.11 Contractor Responsibilities for Design and Development Phase

1. Produce all deliverables required below and those required under Section 50.4 for Large Projects for the design and development of FMMIS/DSS; and
2. Conduct Joint Application Design (JAD) sessions involving State stakeholders to determine specific requirements and design elements to be incorporated into FMMIS/DSS:
   a. Provide feedback to the State through screen and report templates, prototypes, flow charts and walk-throughs; and
   b. Document JAD session requirements and create methods to measure delivery of approved design components.

50.1.1.12 Design and Development Milestones and Deliverables

The State must approve the content and format of all deliverables at the outset of the Design and Development Phase. The State 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.

Minimum content for deliverables is outlined in Section 50.4. Deliverables standards are described in Section 40.1.4. The Contractor is responsible to provide all

additional documents and materials necessary to support its Information Systems Development Methodology (ISDM) at the appropriate time, whether itemized in these lists or not.

The Milestones numbered below must be completely met before payments in Pricing Schedule B-1 may be made. For milestones with multiple deliverables, the list of deliverable requirements is shown in the lettered list.

1. Completion of Planning Activities:
    a. Stakeholder analysis;
    b. Work Breakdown Structure (WBS)/Detailed Implementation Plan (DIP);
    c. Risk Management Plan;
    d. Identified Risks, Risk Analysis and Risk Response Plan;
    e. Communication Management Plan;
    f. Cost and Budget Estimates;
    g. Staffing Management Plan;
    h. Project Schedule; and
    i. Quality Management Plan.
2. Completion of all Requirements Analysis Documents;
3. Completion of Business and Technical Design:
    a. Business Design Document;
    b. Technical Design Document;
    c. State and Contractor staff Training Plan; and
    d. All other documentation for business and technical design based on the ISDM approved by the State (See Section 50.1.1.3, Business and Technical Design).
4. Completion of Comprehensive Testing Plan;
5. Completion of Design and Development, Start of Readiness Testing Period:
    a. Contractor letter certifying FMMIS/DSS completion;
    b. Successful execution of Training Plan; and
    c. System Documentation;
6. Conclusion of User Acceptance Testing:
    a. State approval to begin operations;
    b. State approval of all status and progress reports:
        (1) Weekly, Monthly and Quarterly Status Reports;
        (2) Monthly Quality Control Reports;
        (3) Monthly Cost Variance Reports; and
        (4) Monthly Schedule Variance Reports.

50.1.2 Implementation Planning Phase

Upon receipt of the Authorization to Begin Work, the Contractor will begin an Implementation Planning Phase. During this phase, the Contractor will plan and prepare to assume all responsibilities of the Florida Medicaid fiscal agent. The Contractor must convert all data necessary to operate FMMIS/DSS and meet all requirements. The Contractor must plan to phase in operations on a schedule that will minimize risk. The Implementation Planning Phase will end upon successful assumption of all fiscal agent responsibilities and resolution of startup issues. The scheduled end of this phase will be on or about October 1, 2007.

50.1.2.1 Data Conversion

The Contractor must convert all data from the existing FMMIS and DSS necessary to operate FMMIS/DSS and produce comparative reports for previous periods of operation. Data must crosswalk to allow continued application of all edits, audits, service authorizations, drug exception requests, rebates, and calculations, and to meet all other system processing requirements. Data conversion must allow State and Contractor staff the ability to view data transparently from previous periods in FMMIS/DSS, including images of claims, provider files, and other documents imaged in the existing FMMIS. Data must crosswalk to allow production of all reports required for system operation, policy decision-making, and federal and State reporting requirements. All routines for data conversion must be tested and approved by the State before application. Data conversion must be complete before the five-month parallel and user acceptance testing period begins, and must be reapplied before implementation of the new system. The Contractor must provide a formal Data Conversion Plan addressing all of these elements before Requirements Analysis is complete. The Contractor must describe in significant detail its approach to data conversion in response to this RFP.

50.1.2.2 Planning

The Contractor must conduct all planning activities associated with the assumption of fiscal agent responsibilities as defined in Section 50.4 for Large Projects. The Contractor must create and submit for State approval a schedule for assumption of all fiscal agent processes and include a draft schedule in response to this RFP.

50.1.2.3 Requirements Analysis

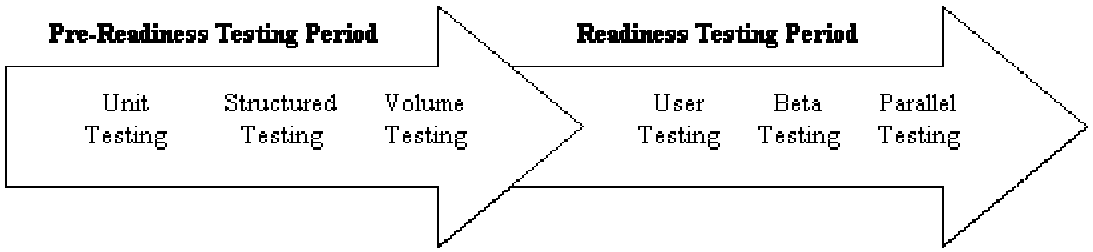
The Contractor must conduct a thorough Requirements Analysis using steps and producing deliverables as required for Large Projects under Section 50.4. State stakeholders must be identified by the Contractor and will be active participants in the process. The Contractor must also produce Requirements Analysis documentation, in formats approved by the State.

50.1.2.4 Cooperation with Incumbent

During the Implementation Planning Phase, the Contractor (if other than the incumbent) must cooperate and work in good faith with the incumbent fiscal agent. The incumbent fiscal agent will have a turnover plan, and the State will coordinate and negotiate differences in the incumbent's turnover plan and the Contractor's plan for assumption of fiscal agent business functions.

50.1.2.5 Comprehensive Testing Plan Prior to Contractor Assumption of Fiscal Agent Responsibilities

The Contractor must create and deliver to the State comprehensive and thorough testing plans before data conversion and implementation begins. This testing plan must incorporate Unit, Structured and Volume testing which occur prior to the Readiness Testing Period and User, Beta and Parallel Testing which are components of the Readiness Testing Period as illustrated in the diagram below.



Unit Tests

Testing must include bench or unit tests to ensure that data conversion meets the intended purpose and does not cause system errors upon execution of programs, batches, or procedures.

Structured Data Tests

The Contractor will create test scenarios or use cases before data conversion with anticipated outcome for each scenario. When structured data tests are run, the Contractor must present a report on the structured data test to the State, including the anticipated and actual outcomes. The Contractor must include any scenarios submitted by the State. All discrepancies must be identified and explained.

Volume Tests

The Contractor must aggressively test for production based on estimates of transaction volume supplied by the State. The Contractor must use volume simulating tools and methods, and must include a description of its volume testing plan and schedule in response to this RFP.

Operations Readiness Tests

The Contractor must prove to the State that it is ready to assume all fiscal agent functions using FMMIS/DSS. This testing must include demonstrations, load testing and results, staff readiness testing, and communications testing. The Contractor must include a description of its operations readiness testing strategy, methodology and schedule in response to this RFP.

Parallel Tests

The Contractor must plan parallel tests of FMMIS/DSS to compare fiscal agent data with converted data. Parallel tests of FMMIS/DSS must be real tests on actual data; therefore, data conversion must be complete through the testing date before parallel testing can begin. The State requires at least five months of parallel testing, to ensure that all functions are working properly. The Contractor must include a description of its parallel testing strategy, methodology and schedule in response to this RFP.

Beta Tests

For system components that affect external users, such as Web portals, Web-based claims submission, claims software, and data entry by other contractors, the Contractor must have a Beta testing plan, allowing external users to participate in the testing process. The Contractor must describe its approach to Beta testing in response to this RFP.

User Acceptance Tests

System acceptance depends on a final, disciplined set of tests by the State for User Acceptance Testing. The Contractor will draft a design and schedule for user acceptance tests early in the development of test plans. The State will review, modify and approve the User Acceptance Testing plan to make sure all State concerns are addressed. The Contractor must describe its approach to User Acceptance Testing in response to this RFP.

Retesting

The Contractor must have a reasonable and aggressive plan to deal with the situation when tests fail. The Contractor is responsible to meet the overall deadlines for this implementation; therefore, the Contractor must include a description of its strategy and methodology for dealing with the situation where unit tests, structured data tests, operation readiness tests or parallel tests fail to produce the desired results.

50.1.2.6 Risk Analysis and Contingency Planning

The size of this project represents significant risk to the State. The Contractor must conduct all risk management activities associated with the design and development of FMMIS/DSS as defined in Section 50.4 for Large Projects. The State will place special scoring emphasis on the Contractors control and management of project risks in this phase of the project. The Contractor must create a Special Contingency Plan, subject to State approval, to execute in case any part of FMMIS/DSS does not perform according to specifications. In particular, the plan must include a method for paying providers in case claims cannot be properly received and processed.

50.1.2.7 Testing

The Contractor must execute the Comprehensive Testing Plan for this project phase.

50.1.2.8 State Acceptance Testing

The State will review test results, with a special focus on structured data tests, parallel tests, and retests of failed items. The State will not accept FMMIS/DSS until all tests pass to the satisfaction of the State. The Contractor must revise and retest as often as necessary to meet State requirements.

50.1.2.9 State Responsibilities for Implementation Planning Phase

1. Provide an Implementation Team of up to twelve (12) individuals with duties that include working with the Contractor on the assumption of fiscal agent responsibilities;

2. Participate in Joint Application Design sessions to assure that the Contractor has adequate understanding of the State role, Contractor role and system requirements for the transition of each business function;
3. Review all work plans, requirements documents, and all deliverables defined in Section 50.4 for Large Projects and provide quick response and comment. The standard turnaround for State review shall be five to seven work days. The State encourages early submission of draft documents to expedite State review;
4. The Implementation Team must transmit final documents and deliverables that are subject to review by AHCA officials, other State officials or federal officials to them for review, and deliver results of any such review to the Contractor; and
5. Approve the beginning of each actual implementation component upon successful conclusion of all activities described in this phase for that task.

50.1.2.10 Contractor Responsibilities for Implementation Planning Phase

Produce all deliverables listed below and required under Section 50.4 for Large Projects for the design and development of FMMIS/DSS.

50.1.2.11 Implementation Planning Milestones and Deliverables

The State must approve the content and format of all deliverables at the outset of the Implementation Planning Phase. The State 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.

Minimum content for deliverables is outlined in Section 50.4. Deliverables standards are described in Section 40.1.4. The Contractor is responsible to provide all additional documents and materials necessary to support its Information Systems Development Methodology (ISDM) at the appropriate time, whether itemized in these lists or not.

The Milestones numbered below must be completely met before payments in Pricing Schedule B-1 may be made. For milestones with multiple deliverables, the list of deliverable requirements is shown in the lettered list.

1. Completion of Planning Activities:
    a. Stakeholder Analysis;
    b. Work Breakdown Structure (WBS)/Detailed Implementation Plan (DIP);
    c. Risk Management Plan;
    d. Identified Risks, Risk Analysis and Risk Response Plan;
    e. Communication Management Plan;
    f. Cost and Budget Estimates;
    g. Staffing Management Plan;
    h. Project Schedule; and
    i. Quality Management Plan.
2. Completion of Requirements Analysis:
    a. Completion of all Requirements Analysis Documents; and

b. Completion of Disaster Recovery and Back-up Plan.

3. Completion of Comprehensive Testing Plan;
4. Completion of Business and Technical Design:
   a. Any Business Design Documents or Technical Design Documents that may be required to assume existing business functions and not covered in the Design and Development Phase;
   b. Completion of the Data Conversion Plan; and
   c. All procedure manuals necessary or stipulated for each operational area, including all specific procedure manual requirements of Section 40.
5. Completion of Implementation Planning, Start of Readiness Testing Period:
   a. Contractor letter indicating readiness to assume all fiscal agent functions; and
   b. Completion of Special Contingency Plan.
6. Conclusion of User Acceptance Testing:
   a. State approval to begin operations; and
   b. State approval of all status and progress reports:
      (1) Weekly, Monthly and Quarterly Status Reports;
      (2) Monthly Quality Control Reports;
      (3) Monthly Cost Variance Reports; and
      (4) Monthly Schedule variance Reports.

50.1.3 Implementation Phase

In its response to this RFP, the Contractor must include a proposed Implementation Phase to be negotiated with the State during the Implementation Planning Phase. The Implementation Phase must address the State's desire for a phased-in implementation to reduce risk. This phase will begin on or about April 1, 2007, and end after successful completion of all post implementation activities, on or about October 1, 2007.

50.1.3.1 Implementation

Upon completion of Implementation Planning activities and the FMMIS/DSS Design and Development Phase for components of FMMIS/DSS, the State will authorize final dates for the implementation of components, based on phased dates in the approved implementation schedule. The Contractor must implement FMMIS/DSS without interruption in recipient eligibility verification, provider enrollment, or claims payment. (See Liquidated Damages Section 30)

50.1.3.2 Correction and Adjustment Activities

The Contractor must monitor the implemented FMMIS/DSS for quality control and verification that all activities are functioning properly. The Contractor must expeditiously repair or remedy any function that does not meet standards set during system definition and the quality planning process. The Contractor must inform the State within one hour of its awareness of any significant implementation problem.

50.1.3.3 Execution of Contingency Plans

If any part of FMMIS/DSS does not perform according to specification, the Contractor must execute the appropriate section of its Special Contingency Plan (See Section 50.1.2.6).

50.1.3.4 State Responsibilities for Implementation Phase

1. Provide an Implementation Team of up to twelve (12) individuals with duties that include working with the Contractor on the implementation of fiscal agent responsibilities;
2. Participate in Joint Application Design sessions to assure that the Contractor has adequate understanding of the State role, Contractor role and system requirements for implementation of each business function;
3. Review all work plans, schedules, contingency plans, and all deliverables defined in Section 50.4 for Large Projects and provide quick response and comment. The standard turnaround for State review shall be five to seven work days. The State encourages early submission of draft documents to expedite State review;
4. Approve the implementation of each component prior to implementation; and
5. Execute any State decision-making or other State responsibilities associated with the Special Contingency Plan.

50.1.3.5 Contractor Responsibilities for Implementation Phase

Produce all deliverables listed below and required under Section 50.4 for Large Projects.

50.1.3.6 Implementation Milestones and Deliverables

The State must approve the content and format of all deliverables at the outset of the Implementation Phase. The State must approve each and every Implementation Phase activity before it occurs. The State 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.

All Milestones and Deliverables numbered below must be completely met before the payment for Correction and Adjustment Activities in Pricing Schedule B-1 may be made.

1. State approval of the implementation schedule;
2. Implementation of each component;
3. Completion of implementation of all components:
4. Documentation of implemented components;
5. Documentation of any problems with implementation and resolution;
6. Ongoing status and progress reports; and
7. Completion of all correction and adjustment activities.

50.1.4 Operations Phase

This phase will begin on or before July 1, 2007, and end on or about June 30, 2012, or as extended by the exercise of contract provisions or amendments to the contract.

50.1.4.1 Operations Requirements

The Contractor must operate FMMIS/DSS and perform all functions described in Section 40 from the date of implementation of each component until each function is turned over to a successor fiscal agent at the end of the contract, including any optional additional periods or extensions.

50.1.4.2 Communication with the State

All written and official electronic correspondence between the Contract Manager and the Contractor must be logged, imaged, archived and maintained by the Contractor for seven years beyond the term of the contract and any extensions of the contract. The Contractor must provide the State with electronic access to this correspondence, including access to images of all written correspondence.

50.1.5 MMIS Certification Phase

The Contractor must design, develop and implement a system that can and will be a certified MMIS by the US Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) and qualify for the highest eligible rate for Federal Financial Participation (FFP) retroactive to the first day of operations.

50.1.5.1 Planning

The Contractor must conduct all planning activities associated with MMIS Certification as defined in Section 50.4 for Large Projects. The Contractor must create a schedule for MMIS Certification activities and submit the schedule for State approval.

General Planning with State

The State will be the point of contact with CMS, and will supply information for the WBS for this task. The Contractor must track both State and Contractor responsibilities associated with MMIS Certification.

Plan to Demonstrate Fulfillment of Federal Requirements

The Contractor must create a Demonstration Plan to prove fulfillment of all federal requirements by running reports, analyzing samples, providing walk-throughs and demonstrations, and providing completed system documentation to the State and CMS.

Plan to Demonstrate Functional Equivalence

For any subsystem requirement in the State Medicaid Manual, Part 11, which was fulfilled under the Medicaid Information Technology Architecture (MITA) or that otherwise, is not apparent in FMMIS/DSS, the Contractor must demonstrate functional equivalence to the satisfaction of CMS. The Contractor is responsible for all functions requiring MMIS certification.

50.1.5.2 Meet with Federal and State Certification Team

When CMS and the State schedule certification meetings, the Contractor must participate and defend FMMIS/DSS.

Generate Test Results

The Contractor must execute any test requested by the State and CMS.

Explain and Model System Operations

The Contractor must execute its plan to demonstrate fulfillment of federal requirements and functional equivalency.

Respond to Questions

The Contractor must respond to any questions from CMS or the State during the certification process.

50.1.5.3 System Remediation

The Contractor is required to deliver a certifiable MMIS for the proposed price. The Contractor must expeditiously correct any item that CMS will not certify on a schedule to be approved by CMS and the State.

Correction of Items Not Certified

The Contractor must correct all items not certified at no additional charge to the State.

Change Control for Certification

The Contractor must execute appropriate controls for changes made during the certification process, including testing requirements. Change must be managed in accordance with the requirements of Section 50.4.1.4, Project Thresholds, depending on the work requirement for the changes to be made.

50.1.5.4 State Responsibilities

1. Serve as the point of contact with CMS. Communicate all pertinent information from the Contractor to CMS and from CMS to the Contractor;
2. Review and approve the Demonstration Plan;
3. Facilitate certification meetings; and
4. Review and approve FMMIS/DSS changes and schedule.

50.1.5.5 Contractor Responsibilities

1. Prepare Demonstration Plan;
2. Meet with the State and CMS to demonstrate fulfillment of requirements and equivalent functionality;
3. Remediate any conditions found that do not meet certification standards; and
4. Deliver a certified MMIS.

50.1.5.6 Milestones

1. Delivery of the Demonstration Plan;

2. Completion of the demonstration meetings;
3. Completion of any remediation activities; and
4. Certification of the MMIS.

50.1.5.7 Deliverables

1. Demonstration Plan;
2. Certification of the MMIS; and
3. Status Reports and other Project requirements defined in Section 50.4, if remediation is required.

The State must approve the final format and content of all deliverables.

50.1.6 Electronic Health Records Development Phase

The Contractor must design, develop and implement an Electronic Health Records (EHR) component for all Medicaid recipients, and provide access to EHR to Medicaid providers, recipients and others as designated by the State. The Contractor shall control access based on HIPAA Privacy and Security rules, under the direction of the State.

The EHR shall include provider, recipient and all diagnosis and procedure code information from claims; electronic claims attachments; and laboratory, x-ray and similar diagnostic reports in formats to be proposed by the Contractor. All record formats will be subject to State approval.

The Contractor must describe its approach to the development of EHR and the operation and management of system components to provide storage and access of the data.

The date of implementation of EHR is December 31, 2008.

50.1.6.1 Planning

The Contractor must conduct all planning activities associated with EHR as defined in Section 50.4 for Large Projects. The Contractor must create a schedule for EHR activities and submit the schedule for State approval.

50.1.6.2 General Planning with the State

The State will be the sole point of contact with CMS, providers, and recipients for this phase, except as otherwise specifically authorized by the State.

50.1.6.3 Research of Alternative Record Formats for EHR

The Contractor must research and evaluate appropriate record formats for EHR and propose the most appropriate format for the State to review and approve.

50.1.6.4 Research of Alternative Methods to Collect the Required Data

The Contractor must research appropriate methods that can be used to collect the data required to populate EHR that are adequate and satisfy the requirements of the State, without being onerous to the provider community. These methods must be submitted to the State for prior review and approval.

50.1.6.5 Development of HIPAA Privacy and Security Requirements

The Contractor must propose access standards and protocols that meet the requirements of both HIPAA privacy and security regulations. These standards and protocols must be submitted to the State for prior review and approval.

50.1.6.6 Provider/Recipient/Others Outreach Efforts

The Contractor must develop outreach plans to address the concerns of and educate providers, recipients and others designated by the State as EHR is designed and implemented. These outreach plans must be presented to the State for prior review and approval.

50.1.6.7 State Responsibilities for Health Records Development Phase

1. Serve as the point of contact with CMS, providers, recipients, and others unless otherwise directed by the State;
2. Review and approve the Project Work Plan;
3. Review and approve the research related to record formats and data collection methods;
4. Review and approve the privacy and security standards and protocols; and
5. Review and approve the outreach efforts.

50.1.6.8 Contractor Responsibilities for Health Records Development Phase

1. Prepare the Project Work Plan;
2. Research and prepare recommendations for the State for record formats and data collection methods;
3. Research and prepare recommendations for privacy and security standards and protocols;
4. Develop outreach plans for the State to review and approval; and
5. Implement EHR.

50.1.6.9 Milestones

1. Approval of the Project Work Plan;
2. Approval of recommendations on record formats and data collection methods;
3. Approval of privacy and security standards and protocols;
4. Approval of outreach plans; and
5. Successful on-time implementation of EHR.

50.1.6.10 Deliverables

1. Project work plan;
2. Report of research and recommendations on record formats and data collection;
3. Report of research and recommendations on privacy and security standards;

4. Outreach plan for providers, recipients and others designated by the State; and
5. Implementation of EHRs.

The State must approve the final format and content of all deliverables.

50.1.7 MITA Gap Analysis Phase

The Contractor must prepare a gap analysis of the system that is in existence at July 1, 2009, relative to the Medicaid Information Technology Architecture (MITA) principles that exist at that time. This analysis will be delivered to the State by December 31, 2009. This analysis will address each of the business functions of FMMIS/DSS and assess their current level of MITA maturity. The analysis must provide recommendations to improve the level of MITA maturity and an estimate of the steps, time frames needed, and the costs to accomplish those recommendations.

The MITA Gap Analysis must include consideration of State business processes, tasks and functions. The Contractor must conduct joint analysis sessions with the State to understand and map current business flows and processes, and make recommendations to improve the MITA maturity level for Medicaid processes as a whole.

In performing the MITA Gap Analysis, the Contractor must use the MITA system organization and structure of this RFP in decomposing and analyzing each business function. If, at the time of the Gap Analysis, CMS has revised and standardized a MITA structure, that structure and organization may be required instead, at the State's option. The Gap Analysis must provide sufficient decomposition to identify discreet differences in maturity level. It is expected that each functional area (Recipient, Provider, Payment, Outcomes and Reporting) will decompose into 20-40 processes or more that must be analyzed.

50.1.7.1 Planning

The Contractor must conduct all planning activities associated with the MITA Gap Analysis as defined in Section 50.4 for Large Projects. The Contractor must submit a schedule for State approval for the MITA Gap Analysis.

50.1.7.2 General Planning with State

The State will be the point of contact with CMS (if needed) and will supply information for the WBS for this task. The Contractor must track both State and Contractor responsibilities associated with the analysis.

50.1.7.3 State Responsibilities for MITA Gap Analysis

1. Serve as the point of contact with CMS, as needed;
2. Review and approve the MITA Gap Analysis Draft Outline;
3. Review and approve the MITA Project Work Plan; and
4. Review and approve the Final Report.

50.1.7.4 Contractor Responsibilities for MITA Gap Analysis

1. Prepare the Draft Outline;
2. Make required changes to the Draft Outline;

3. Prepare and update the Project Work Plan;
4. Prepare the Draft Final Report;
5. Revise the Final Report based upon State comments; and
6. Present the Final Report as directed by the State.

50.1.7.5 Milestones

1. Approval of the Outline by the State;
2. Approval of the Project Work Plan by the State;
3. Identification of the business functions to be analyzed;
4. Delivery of the Draft MITA Maturity Assessment for each business function;
5. Delivery of draft recommendations; and
6. Approval of the Final Report.

50.1.7.6 Deliverables

1. Draft Outline of the Report for State approval;
2. Project Work Plan updated per schedule;
3. Status Reports;
4. Identification of the business functions to be analyzed;
5. Delivery of the Draft MITA Maturity Assessment for each business function;
6. Delivery of draft recommendations;
7. Draft Final Report;
8. Revised Final Report; and
9. Presentation of the Final Report as required.

The State must approve the final format and content of all deliverables.

50.1.8 Turnover Phase

The Contractor must prepare for turning over responsibilities and operations at the end of the contract. The Contractor must cooperate with the successor fiscal agent, other contractors and the State in the planning and transfer of operations. The Contractor must dedicate special additional resources to this phase. This phase will begin about twelve months before the end of the contract period and end about six months after the end of the contract period, or as extended by the exercise of contract provisions or amendments to the contract. For planning purposes, this phase should begin on or about July 1, 2011 and end on or about December 31, 2012.

50.1.8.1 Planning

The Contractor must conduct all planning activities associated with FMMIS/DSS turnover as defined in Section 50.4 for Large Projects. The Contractor must create a schedule for FMMIS/DSS turnover activities and submit the schedule for State approval.

50.1.8.2 General Planning with State

The State will be the point of contact with CMS and will provide WBS information for this task. The Contractor must track both State and Contractor responsibilities associated with the Turnover Phase.

50.1.8.3 General Planning with Successor

The Contractor will work closely with the successor contractor during the planning for the Turnover Phase.

50.1.8.4 Develop Turnover Plan

The Contractor must provide a Turnover Plan to the State by January 1, 2012. This plan must include:

1. Proposed approach to the turnover;
2. Tasks and sub-tasks for the turnover;
3. Schedule for the turnover; and
4. All FMMIS/DSS production data, program libraries, and documentation, including documentation update procedures for the turnover.

50.1.8.5 Develop FMMIS Requirements Statement

As part of the Turnover Plan the Contractor must furnish to the State a statement of resource requirements that would be required by the State or a successor contractor to take over FMMIS/DSS.

50.1.8.6 Provide Turnover Services

The Contractor will provide the required turnover services.

50.1.8.7 Cooperation with Successor

The Contractor will cooperate with the successor contractor while providing all required turnover services. This will include meeting with the successor and devising work schedules that are agreeable for both State and the successor contractor.

50.1.8.8 Turnover of Archived Materials

When requested by the State, the Contractor must transfer all source program code on magnetic tape or a medium approved by the State. The Contractor will be required to supply all magnetic tapes used in the transfer of data and files and will be responsible for all associated shipping charges.

50.1.8.9 Contract Closeout Services

1. Financial Reconciliation:
    a. Final reconciliation of the FMMIS/DSS bank account;
    b. Final settlement of all outstanding financial transactions in the bank account;
    c. Final settlement of all Contractor invoices;
    d. Final reconciliation of all accounts receivable;

e. Final assessment of any liquidated damages; and

f. An independent audit of the bank account by an entity with no contact or relationship with the Contractor.

2. Written Assessment of Contract Performance. The State will provide a written assessment of the Contractor's contract performance that will include all Performance Reporting System items. Performance Reporting System requirements are described in Section 30.29, Section 40.1.2.1 and Section 40.5.3.6.

3. Resolution of Turnover Issues:

   a. The Contractor must ensure that FMMIS/DSS will be error free and complete when turned over to the State or the successor contractor; and

   b. The Contractor must correct, at no cost to the State, any malfunctions that existed in the system prior to turnover or were caused by the lack of support, by the Contractor, as may be determined by the State.

50.1.8.10 State Responsibilities for Turnover Phase

1. Notify the Contractor of the State's intent to transfer or replace the system at least six (6) months prior to the end of the FMMIS/DSS contract;
2. Review and approve a turnover plan to facilitate transfer of FMMIS/DSS to the State or to its designated agent;
3. Review and approve a statement of resources, which would be required to take over operation of FMMIS/DSS;
4. Make State staff or designated agent staff available to be trained in the operation of FMMIS/DSS;
5. Coordinate the transfer of FMMIS/DSS documentation (in hard and soft copy formats), software and data files;
6. Review and approve a turnover results report that documents completion of each step of the turnover plan; and
7. Obtain post turnover support from the Contractor in the event of software malfunction.

50.1.8.11 Contractor Responsibilities for Turnover Phase

1. The Contractor must supply an estimate of the number, type, and salary of personnel to operate the equipment and other functions of FMMIS/DSS. The estimate shall be separated by type of activity of the personnel, including, but not limited to, the following categories:

   a. Data processing staff;

   b. Computer operators;

   c. Systems analysts;

   d. Systems programmers;

   e. Programmer/Analysts;

   f. Project management staff;

g. Data entry and imaging operators;

h. Provider services staff;

i. Administrative staff;

j. Provider field representatives;

k. Clerks; and

l. Managers.

2. The Contractor must provide a statement that includes all facilities and any other resources required to operate FMMIS/DSS including, but not limited to:

   a. Data processing and imaging equipment;

   b. System and special software;

   c. Other equipment;

   d. Telecommunications circuits;

   e. Telephones; and

   f. Office space.

3. The Contractor must provide a statement that includes all resource requirements based on the Contractor's experience and must include the actual Contractor resources devoted to the operation of FMMIS/DSS;

4. The Contractor must provide a detailed organizational chart depicting the Contractors total FMMIS/DSS operation;

5. The Contractor must transfer to the State or the successor contractor, as needed, a copy of FMMIS/DSS including, but not limited to:

   a. All necessary data and reference files;

   b. Imaged documents stored on optical and magnetic disk;

   c. All production computer programs; and

   d. All production scripts, routines, control language, and schemas.

6. Provide all production documentation including, but not limited to user and operations manuals, system documentation in hard and soft copy needed to operate and maintain FMMIS/DSS and the procedures of updating computer programs and other documentation;

7. The Contractor must provide training to the successor staff in the operation of FMMIS/DSS. Such training must be completed at least two (2) months prior to the end of the contract. Such training shall include:

   a. Data entry, imaging, and claims processing;

   b. Computer operations;

   c. Controls and balancing procedures;

   d. Exception claims processing; and

   e. Other manual procedures.

8. The Contractor must provide updates or replacements for all data and reference files, computer programs, and all other documentation that will be required by the State or the successor contractor to run acceptance tests;
9. On a schedule to be determined by the State, the Contractor must package, insure and deliver all hardware used in FMMIS/DSS to a location in Tallahassee designated by the State;
10. At a turnover date to be determined by the State, the Contractor must provide to the State or the successor contractor all updated computer programs, data, and reference files, and all other documentation and records as will be required by the State or its agent to operate FMMIS/DSS;
11. The Contractor must turn over all:
    a. Paper claims;
    b. Paper provider files;
    c. Paper file maintenance forms; and
    d. Financial paper records.

50.1.8.12 Milestones

1. State approval of Turnover Plan;
2. State approval of FMMIS/DSS requirement statement;
3. Completion of turnover training; and
4. Completion of turnover.

50.1.8.13 Deliverables

1. Turnover Plan;
2. FMMIS/DSS requirement statement;
3. FMMIS/DSS software, files, and system, and user and operations documentation in hard and soft copy format; and
4. Turnover results report.

The State must approve the final format and content of all deliverables.

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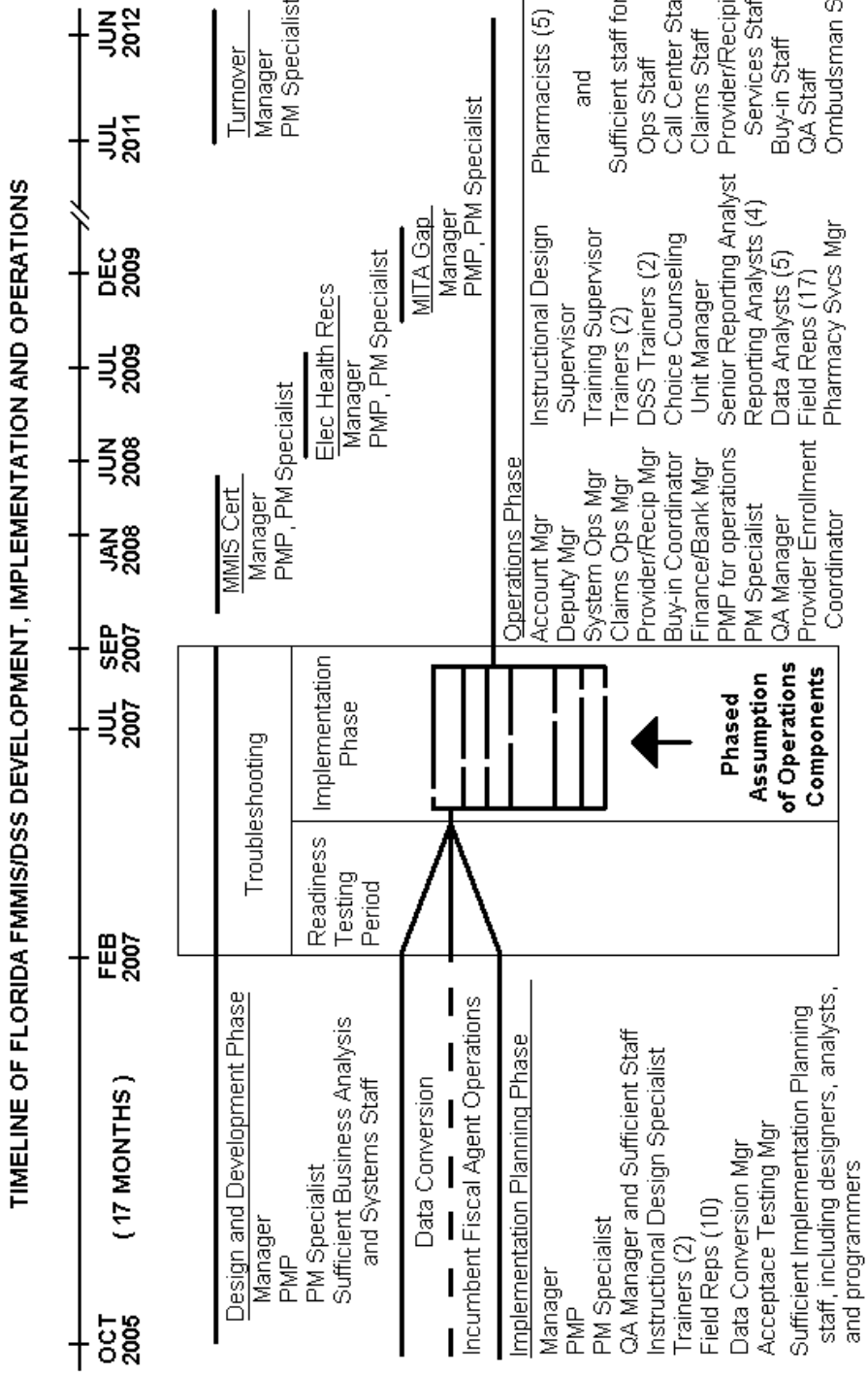
50.2 Staffing Requirements

The Contractor must provide adequate staffing in every phase of the contract. The following illustration presents an overview of the contract phases and staffing requirements.



50.2.1 Definition of Staff

The Vendor must describe its plan and commitment for staffing each phase of the contract. The response must conform to requirements as follows:

Named Staff - The Contractor must include names and resumes for certain high-level positions, must assure that Named Staff meet the qualification requirements, and must assure that Named Staff bid will be devoted to the contract as bid, subject to Liquidated Damages.

Minimum Numbers of Categorized Staff - The Contractor must supply a certain number of staff in categories described in this RFP. The Contractor must maintain the number and qualifications of this staff as required in each phase, subject to Liquidated Damages.

Sufficient Numbers of Categorized Staff - The Contractor must supply sufficient staff to design, develop, implement and operate FMMIS/DSS and to meet all other requirements of the contract. This staff is over and above the Named Staff and the Minimum Numbers of Categorized Staff set by the State. The Vendor must indicate the number of staff planned by category for each phase of the contract, and must maintain at least the level of staffing bid through the first year of operations. The Contractor may not reduce staffing levels without the approval of the State. The Contractor may be required to increase staffing levels if requirements or standards are not being met, based solely on the discretion of the State. In making this determination, the State will evaluate whether the Contractor is meeting deliverable dates, producing quality materials, maintaining high quality and production rates, and meeting RFP standards without significant rework or revision.

To assure consistency of response, all staff bid, whether Named Staff or Categorized Staff, must meet the definitions provided in Section 50.2.1.1 and Section 50.2.1.2. Staff positions are also organized into Cost Categories that must match the pricing schedules (See Section 60, Pricing Schedule B, Pricing Schedules C-1 through C-5, Pricing Schedule D and Pricing Schedule E) to assure consistency in pricing.

50.2.1.1 Named Staff Definition and Qualifications

Named Staff are those staff members with the following titles. Named Staff must be available for assignment on FMMIS/DSS on a full-time basis and must be solely dedicated to this project. Each Named Staff member must have the required MMIS or DSS experience. Any proposed change to this staff after contract execution must have prior approval by the State. Resumes for this staff must be supplied with the proposal. Resumes of other staff shall be provided at the request of the State.

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Named Staff Position and Cost Category	Named Staff Qualifications/Requirements
Systems Development Manager for Design and Development (Management)	Minimum of five (5) years of Medicaid related system design and management experience including the management of one (1) MMIS/DSS systems design and development project similar in size and scope to this project. A bachelor's degree in computer science or a related field is also required.
Project Management Professional for Design and Development (Management)	PMP or equivalent certification (may be the same person as the Systems Development Manager, if PMP certified).
Project Management Specialist for Design and Development (Project Management Staff)	Minimum of two (2) years of project management experience using Microsoft Project. A bachelor's degree in business management or a related field is also required.
Implementation Planning Manager (Management)	Minimum of five (5) years of management experience for government or private sector healthcare payor similar in size and scope to this project. Minimum of three (3) years of MMIS/DSS experience. A bachelor's degree in business management or a related field is also required.
Project Management Professional for Implementation Planning (Management)	PMP or equivalent certification (may be the same person as the Implementation Planning Manager, if PMP certified).
Project Management Specialist for Implementation Planning (Project Management Staff)	Minimum of to (2) years of project management experience using Microsoft Project. A bachelor's degree in business management or a related field is also required.

Named Staff Position and Cost Category	Named Staff Qualifications/Requirements
Quality Assurance Manager for Implementation Planning (Management)	A bachelor's degree with at least three (3) courses in statistics and/or quality assurance and a minimum of three (3) years progressive experience in the quality assurance function of a large scale claims processing organization or have at least five (5) years progressive experience in the quality assurance function of a large scale claims processing organization.
Data Conversion Manager (Management)	At least three (3) years experience in the conversion of large-scale health data, with at least one (1) year in a management capacity.
User Acceptance Testing Manager (Management)	At least two (2) years experience conducting and operating acceptance tests for a major customer in a MMIS or major health plan or claims processing environment.
Account Manager (Management)	Minimum of five (5) years of account management experience for a government or private sector health care payor, including a minimum of three (3) years MMIS experience in a state of equivalent scope to Florida. A bachelor's degree in business management or a related field is also required.
Deputy Account Manager (Management)	Minimum of four (4) years of account management experience for a government or private sector health care payor, including a minimum of two (2) years MMIS experience in a state of equivalent scope to Florida. A bachelor's degree in business management or a related field is also required.
Operational Systems Group Manager (Management)	Minimum of four (4) years of MMIS operation experience as manager in a state of equivalent scope to Florida. A bachelor's degree in computer science or a related field is also required.

Named Staff Position and Cost Category	Named Staff Qualifications/Requirements
Claims Operations Manager (Management)	A bachelor's degree and minimum of four (4) years experience managing claims processing operations and personnel for a government or private sector health care payor, including a minimum of two (2) years MMIS experience.
Provider/Recipient Services Manager (Management)	A bachelor's degree and minimum of four (4) years experience managing provider relations functions for a Medicaid program, other government health care program, or health care related organization. Experience and/or training in recipient eligibility management and significant experience in a call center operation are also required.
Buy-In Coordinator (Supervision)	A bachelor's degree and at least two (2) years of experience determining eligibility for Medicare savings programs or dual Medicare/Medicaid eligibility; a thorough knowledge of buy-in processing and the federal buy-in files and file structures.
Finance/Banking Manager (Management)	Degree in Finance or Accounting, active and licensed Certified Public Accountant (CPA) or Certified Internal Auditor (CIA) with five (5) years of banking, accounting or auditing experience in a large-scale operation.
Project Manager for Operations (Management)	Minimum of four (4) years of project management experience on Large Projects. Must be a Certified Project Management Professional (PMP) or have a comparable project management certification.
Project Management Specialist for Operations (Project Management Staff)	Minimum of two (2) years of project management experience using Microsoft Project. A bachelor's degree in business management or a related field is also required.

Named Staff Position and Cost Category	Named Staff Qualifications/Requirements
Quality Assurance Manager for Operations (Management)	A bachelor's degree with at least three (3) courses in statistics and/or quality assurance and a minimum of three (3) years progressive experience in the quality assurance function of a large scale claims processing organization or have at least five (5) years progressive experience in the quality assurance function of a large scale claims processing organization.
Certification Manager (Management)	Minimum of five (5) years of Medicaid related system design and management experience including the management of one (1) MMIS/DSS systems design and development project similar in size and scope to this project. A bachelor's degree in computer science or a related field is also required. (This person should be the same as the Systems Development Manager.)
Project Management Professional for Certification (Management)	PMP or equivalent certification (may be the same person as the Certification Manager, if PMP certified).
Project Management Specialist for Certification (Project Management Staff)	Minimum of two (2) years of project management experience using Microsoft Project. A bachelor's degree in business management or a related field is also required.

50.2.1.2 Categorized Staff Definition and Qualifications

Categorized Employees are those staff required to be maintained by the Contractor in agreed quantities by category, either as part of the Minimum Numbers of Categorized Staff required in this RFP, or as part of the Sufficient Numbers of Categorized Staff described in the Vendor's proposal.

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Categorized Employees

Categorized Employee Positions and Cost Category	Categorized Employee Qualifications/Requirements
Manager (Management)	Minimum bachelor's degree and 2 years of management experience (additional management experience may substitute for the degree on a year-for-year basis). One (1) year of MMIS experience is also required.
Supervisor (Supervision)	Minimum bachelor's degree and 2 years of supervisory experience managing at least 4 people (additional supervisory experience may substitute for the degree on a year-for-year basis).
Pharmacist or Pharmacy Technician (Medical Professionals)	Appropriate medical credential, such as current license or specialty certificate; not under suspension from Medicare, Medicaid, practice in Florida; and not previously sanctioned for fraud or abuse.
Professional (Other Professionals)	Minimum professional degree or certification and 2 years experience in the professional field.
Data Base Administrator (Data Administrator)	Minimum bachelor's degree and four (4) years MMIS DBA experience.
MMIS Application Senior Systems Analyst (Senior Programmer/Analyst)	Minimum bachelor's degree and three (3) years of MMIS experience.
MMIS Systems Engineer (Data Administrator)	Minimum bachelor's degree and two (2) years experience in systems design and engineering.
MMIS Application Programmer/Analyst (Programmer/Analyst)	Minimum programming degree or certification and two (2) years of programming experience.
Internet/Intranet Programmer Analyst (Programmer/Analyst)	Minimum programming degree or certification and two (2) years Web-based programming experience.

Categorized Employee Positions and Cost Category	Categorized Employee Qualifications/Requirements
PC Programmer Analyst (Programmer/Analyst)	Minimum programming degree or certification and two (2) years PC programming experience.
Documentation Specialists (Programmer/Analyst)	Minimum programming degree or certification and three (3) years technical writing experience.
Data Entry Operator (Clerical)	Minimum one (1) year data entry experience in an environment similar to the business function proposed
Project Management Specialist (Project Management Staff)	Minimum of two (2) years project management experience with MS Project.
Clerical Staff (Clerical)	Education or training relevant to the business function, with no additional specified education or experience requirement.
Provider Enrollment Coordinator (Supervision)	Minimum bachelor's degree and two (2) years of supervising provider enrollment or credentialing activities for Medicaid, Medicare or a large health network.
Provider Field Representative (Field Representative)	A bachelor's degree and one (1) year experience in the health care billing or health care public relations field. Experience can be substituted for the bachelor's degree on a year-for-year basis.
Instructional Design Specialist (Other Professionals)	A bachelor's degree and two (2) years of instructional design professional experience in training, education, staff development, personnel or an Agency program area. A master's degree can substitute for a year of experience and a doctorate can substitute for experience.

Categorized Employee Positions and Cost Category	Categorized Employee Qualifications/Requirements
Training Supervisor (Supervision)	A bachelor's degree and two (2) years experience in training education, staff development, personnel or an Agency program area, and at least one (1) year of supervisory experience. A master's degree can substitute for one year of experience and a doctorate can substitute for two years of experience. Experience as described above can substitute on a year-for-year basis for the required college education.
Training Specialists (Trainer/Publications)	A bachelor's degree and two (2) years experience in training, education, staff development, personnel or an Agency program area. A master's degree can substitute for a year of experience and a doctorate can substitute for experience. Experience can substitute on a year-for-year basis for the required college education.
Publications Coordinator (Trainer/Publications)	A bachelor's degree and three (3) years experience in the publication of bulletins and technical handbook material. Experience in the health care public relations and health care publications preferred.
Quality Assurance Support Staff (QA Staff)	High School diploma and three (3) years Medicaid or health care quality assurance support experience.
Telephone/Inquiry Support Staff (Service Representative)	High school diploma and three (3) years Medicaid or health care telephone support experience or completion of a State-approved training program for Medicaid telephone support.
Buy-In Coordinator (Supervision)	College degree and two (2) years of either medical eligibility determination or Medicare Buy-in experience is required.
Buy-In Processing Staff (Service Representative)	College degree and one (1) year Medicaid Buy-in processing experience, and completion of a State-approved training program for Buy-in.

Categorized Employee Positions and Cost Category	Categorized Employee Qualifications/Requirements
EHR Project Manager for Electronic Health Records (Management)	Minimum of three (3) years experience managing projects related to electronic health records. A bachelor's degree in health data management or a related field is also required.
EHR Project Management Professional (Management)	Minimum of two (2) years of project management experience on Large Projects. Must be a Certified Project Management Professional (PMP) or have a comparable project management certification.
EHR Project Management Specialist (Project Management Staff)	Minimum of two (2) years of project management experience using Microsoft Project. A bachelor's degree in business management or a related field is also required.
MITA Gap Analysis Manager (Management)	Minimum of three (3) years experience managing MMIS or performing Gap Analyses for MMIS or major health plans. Knowledge of MITA requirements and a bachelor's degree in data analysis, business administration or a related field is also required.
MITA Project Management Professional (Management)	Minimum of three (3) years of project management experience on Large Projects. Must be a Certified Project Management Professional (PMP) or have a comparable project management certification.
MITA Project Management Specialist (Project Management Staff)	Minimum of two (2) years of project management experience using Microsoft Project. A bachelor's degree in business management or a related field is also required.
Turnover Manager (Management)	A bachelor's degree and at least three (3) years MMIS experience, and experience turning over operations similar in size and scope to Florida. Sufficient delegation of management authority to make decisions and obligate Contractor resources to fulfill obligations of the Turnover Phase.

Categorized Employee Positions and Cost Category	Categorized Employee Qualifications/Requirements
Turnover Project Management Specialist (Project Management Staff)	A bachelor's degree and at least two (2) years of project management experience using Microsoft Project. A bachelor's degree in business management or a related field is also required.

50.2.2 General Requirements for Employees

50.2.2.1 Residency and Work Status

The Contractor must follow all federal and state laws regarding Social Security registration and legal work status of all staff employed or contracted by the Contractor.

50.2.2.2 Background Checks

All Contractor employees working on FMMIS/DSS must have a criminal background check done within one week of employment, with results submitted to the State for review. Any employee with a background unacceptable to the State must be immediately dismissed from the project by the Contractor.

50.2.2.3 Bonding

All Contractor staff working in the following areas must be bonded: Named Staff, Provider Communications (call-center), Provider Enrollment, Banking, Finance, Audit, and Systems Security.

50.2.3 Staffing Requirements for the Design and Development Phase

The Contractor must demonstrate its ability to recruit skilled and highly qualified staff and to implement all aspects of the work required during the Design and Development Phase of FMMIS/DSS within the stated time frames. Staffing levels must be sufficient to complete all of the responsibilities outlined for this task. All Named Staff for the Design and Development Phase must remain on the project until implementation is complete.

50.2.3.1 Named Staff

The commitments for the following Named Staff must extend through the development and implementation of FMMIS/DSS and be one hundred percent (100%) dedicated to the project.

1. One (1) Systems Development Manager for Design and Development. (Resume required) This person may not hold any other concurrent position during the Design and Development Phase. This person should become the MMIS Certification Manager, and may also be proposed as the Electronic Health Records Development Manager, and/or MITA Gap Analysis Manager.
2. One (1) Project Management Professional (PMP) for Design and Development. (Resume required) This person may be the same as the Systems Development Manager, if the Systems Development Manager meets PMP certification

requirements and if all RFP requirements can be met without dedicating additional PMP resources. Otherwise, this person may not hold any other concurrent position during the Design and Development Phase. This person should become the MMIS Certification PMP, and may also be proposed as the Electronic Health Records Development PMP, and/or MITA Gap Analysis PMP.

3. One (1) Project Management Specialist for Design and Development. (Resume required) This person may serve as the Project Management Specialist for both Design and Development and Implementation Planning Phases concurrently if all RFP requirements can be met without dedicating additional Project Management Specialist resources.

50.2.3.2 Sufficient Numbers of Categorized Staff

The Vendor must determine the level of management and technical staffing necessary to complete the design and development of FMMIS/DSS on schedule. The Vendor must describe in its proposal the number, qualifications and type of staff proposed, based on the categories described in Section 50.2.1.2, Categorized Staff Definition and Qualifications. The proposed staffing plan must be sufficient to complete all of the responsibilities outlined for the Design and Development Phase on FMMIS/DSS, and to complete all tasks on schedule. If the number and type of staff is determined by the State to be inadequate, the Contractor must provide as many additional qualified staff members as necessary without additional cost to the State.

50.2.4 Staffing Requirements for Implementation Planning Phase

The Contractor must demonstrate its ability to recruit skilled and highly qualified staff and to implement all aspects of the work required during the Implementation Planning Phase on FMMIS/DSS within the stated time frames. Staffing levels must be sufficient to complete all of the responsibilities outlined for this task.

50.2.4.1 Named Staff

The commitments for the following Named Staff must extend through the Implementation Planning Phase on FMMIS/DSS. None of these individuals may have dual primary responsibilities during the Implementation Planning Phase or in the concurrent Design and Development Phase.

1. One (1) Implementation Planning Manager (Resume required);
2. One (1) Project Management Professional (PMP) for Implementation Planning. (Resume required) This person may be the same as the Implementation Planning Manager, if the Implementation Planning Manager is PMP certified and if all RFP requirements can be met without dedicating additional PMP resources;
3. One (1) Project Management Specialist for Implementation Planning. (Resume required) This person may serve as the Project Management Specialist for both Design and Development and Implementation Planning Phases concurrently if all RFP requirements can be met without dedicating additional Project Management Specialist resources; and
4. One (1) Quality Assurance Manager for Implementation Planning. (Resume required) The Quality Manager must have sufficient authority within the

Contractor's organization to implement corrective action plans and measures identified by the State or by quality management staff.

5. One (1) Data Conversion Manager. (Resume required) The Data Conversion Manager is responsible to manage all data conversion activities, and must be dedicated to this task full time from the beginning of the Implementation Planning Phase through the end of the Implementation Phase.
6. One (1) User Acceptance Testing Manager. (Resume required) The User Acceptance Testing Manager is responsible to supervise all user acceptance testing activities, and must be dedicated to this task full time beginning at least three months before the Readiness Testing Period and ending upon successful conclusion of the Readiness Testing Period.

50.2.4.2 Minimum Numbers of Categorized Staff

1. One (1) Instructional Design Specialist;
2. Two (2) Training Specialists; and
3. Ten (10) Field Representatives, beginning on January 1, 2007, to conduct provider orientation and training for FMMIS/DSS.

50.2.4.3 Sufficient Numbers of Categorized Staff

1. Implementation Planning Staff. The Vendor must determine the level of technical staffing necessary to complete the Implementation Planning Phase of FMMIS/DSS on schedule. The Vendor must describe in its proposal the number, qualifications and type of staff proposed, based on the categories described in Section 50.2.1.2, Categorized Staff Definition and Qualifications. The proposed staffing plan must be sufficient to complete all of the responsibilities outlined for the Implementation Planning Phase on FMMIS/DSS.
2. Quality Assurance Support Staff – The Contractor must provide sufficient support staff to carry out quality assurance functions during the Implementation Planning Phase. This unit will be responsible for assuring that the Contractor meets its responsibilities for all other systems in FMMIS/DSS. The Vendor must indicate the number of additional Quality Assurance Support Staff proposed for this phase, based on the qualifications described in Section 50.2.1.2, Categorized Staff Definition and Qualifications.

50.2.5 Staffing Requirements for Operations Phase

50.2.5.1 Named Staff

The following Named Staff will be required to provide a two (2) year commitment to FMMIS/DSS from the date the State authorizes implementation of claims processing operations. None of these individuals may have dual primary responsibilities during the Operations Phase of the contract and must be 100% dedicated this project.

1. One (1) Account Manager (Resume required);
2. One (1) Deputy Account Manager (Resume required);
3. One (1) Operational System Group Manager (Resume required);
4. One (1) Claims Operations Manager (Resume required);

5. One (1) Provider/Recipient Services Manager (Resume required);
6. One (1) Buy-In Coordinator (Resume required);
7. One (1) Finance/Banking Manager (Resume required);
8. One (1) Project Manager for Operations (Resume required). This individual may not have dual primary responsibilities;
9. One (1) Project Management Specialist for Operations (Resume required); and
10. One (1) Quality Assurance Manager (Resume required).

50.2.5.2 Minimum Numbers of Categorized Staff

1. One (1) Provider Enrollment/Reenrollment Coordinator;
2. Seventeen (17) Provider Field Representatives;
3. Twenty-five (25) Modernization and Modification Systems Staff. The Contractor must provide this staff to analyze systems and business processes, design and implement technical solutions to continuously modernize modify FMMIS/DSS, over and above any staff used for general system operations and maintenance. This staff will be required to implement changes requested or approved by the State. This function is intended to make the system more efficient, improve its interoperability, and to meet any new state or federal requirements. This staff must be comprised of employees categorized under the requirements of Section 50.2.1.2.
    a. The Vendor must propose a staffing plan with the proper mix and organization of individuals. The State retains the right to negotiate an increase or decrease in the size of this staff based on experience. In the event the State determines an adjustment to the size of the staff is necessary, a thirty (30) day notice will be given to the Contractor; and
    b. The State will establish priorities for this staff and require allocation of staff to certain areas of responsibilities. The Vendor should indicate the distribution of this staff to provide quick response to Customer Service Requests, professional analysis of proposed system changes, efficient and productive programming to implement State-approved solutions, and quality-controlled implementation and documentation. The Contractor must maintain the required level of staffing during the Operations Phase (See Liquidated Damages in Section 30).
4. One (1) Instructional Design Specialist to work in a unit for the training of State staff and providers to include scheduling of multiple training sessions, arranging for interface with provider associations for participation, creating and maintaining invitation/registration lists, developing training materials and preparing annual training plan and training reports;
5. One (1) Training Supervisor to work in the training unit described above;
6. Two (2) Training Specialists to work in the training unit described above;
7. One (1) Choice Counseling Unit Manager;
8. One (1) Senior Programmer/Analyst for data analysis to meet information reporting requirements of the State. This individual may not be assigned other

maintenance or modification task assignments, unless otherwise directed by the State;

9. Four (4) Programmer Analysts for data analysis to meet information reporting requirements of the State. This staff may not be assigned other maintenance or modification task assignments, unless otherwise directed by the State;
10. Five (5) Professional Data Analysts to work at the Agency facilities to support the Medicaid program and provide knowledgeable analytical assistance to Medicaid senior management. The team shall consist of highly qualified and experienced data/statistical analysts who have extensive training and experience with a Medicaid DSS, analyzing Medicaid and other health care data, experience with Medicaid and Medicare populations, the Medicaid and Medicare programs, excellent writing skills, knowledge of analytical tools, statistical packages and an extensive research background;
11. Five (5) Registered Pharmacists to conduct on-site visits to prescribers providing them with educational materials and academic detailing information. These staff will report to AHCA Medicaid Pharmacy Services;
12. One (1) Pharmacy Services Manager responsible for managing the pharmacy provider relations function;
13. Two (2) Trainers to satisfy training requirements of the DSS. DSS trainers will conduct training at the Agency facilities; and
14. One (1) Publications Coordinator to produce policy bulletins, newsletters, form control, and other document production needs of the Medicaid program.

50.2.5.3 Sufficient Numbers of Categorized Staff

1. Operations Staff. The Contractor must provide sufficient staff to operate and maintain the running of FMMIS/DSS. Staffing for FMMIS/DSS must include an onsite project team to operate the system, support the database, and provide training and customer support:
   a. The Contractor must provide the staffing levels necessary to meet these requirements, based on the categories described in Section 50.2.1.2, Categorized Staff Definition and Qualifications. If the number and type of staff is determined by the State to be inadequate, the Contractor must provide as many additional qualified staff members as necessary without additional cost to the State; and
   b. The Contractor must maintain the level of staffing proposed during the Operations Phase (See Liquidated Damages in Section 30).
2. Telephone/Inquiry Support Staff:
   a. The Contractor must provide sufficient to support provider/recipient phone inquiries and to fulfill the Contractor responsibilities for each of the various call centers described in this RFP:
      (1) Choice Counseling/Enrollment Brokering Call Center (Section 40.2.4.6);
      (2) Eligibility Verification Call Center (Section 40.2.7.6);
      (3) Recipient Call Center (Section 40.2.8.6);
      (4) Provider Call Center (Section 40.3.4.6);

(5) Service Authorization Call Center (Section 40.4.2.6); and

(6) Therapeutic Consultation Call Center (Section 40.5.4.6).

b. The Contractor will establish a training program to ensure that all telephone staff are adequately trained prior to beginning operations and to ensure that a continuous training program is in place to maintain their knowledge and understanding of system and policy changes that affect procedures.

3. Claims Production Staff. The Contractor will provide sufficient staff to support the claims production functions including, but not limited to claims resolution, adjustment/void processing, and Electronic Claims Submission (ECS) support;

4. Provider/Recipient Services Staff. The Contractor will provide sufficient staff to support the provider/recipient services function including, but not limited to, provider enrollment, claims billing inquiries, recipient eligibility verification, written correspondence, provider training schedules, provider publications, provider claims resolution and provider training;

5. Buy-in Staff. Sufficient buy-in staff to meet all of the Contractor's responsibilities described in Section 40.2.5, Buy-In. The Buy-in Coordinator must train the staff who process buy-in;

6. Quality Assurance Support Staff. The Contractor will provide sufficient support staff to carry out quality assurance functions during the Operations Phase. This unit will be responsible for assuring that the Contractor meets its responsibilities for all systems in FMMIS/DSS; and

7. Pharmacy Ombudsman's Office. The Contractor will provide sufficient pharmacists and pharmaceutical personnel to meet the requirements of the Pharmacy Ombudsman's Office described in Section 40.2.8.6 (Recipient Communications Contractor Responsibilities), Item 7.

50.2.6 Staffing Requirements for MMIS Certification Phase

50.2.6.1 Named Staff

The proposed Named Staff must be available to the project on a full-time basis. Their sole responsibility will be to ensure that FMMIS/DSS receives federal certification. Any proposed changes to the management staff after contract execution must have prior approval by the State.

1. One (1) Certification Manager (Resume required). This should be the same individual as proposed for the Systems Development Manager for Design and Development. This individual must be fully dedicated to this project and may not have other responsibilities;

2. One (1) Project Management Professional for Certification (Resume required). This person may be the same as the Certification Manager, if the Certification Manager is PMP certified and if all RFP requirements can be met without dedicating additional PMP resources; and

3. Project Management Specialist for Certification (Resume required).

50.2.6.2 Sufficient Numbers of Categorized Staff

The Contractor will provide sufficient supporting staff to carry out all certification functions. This unit shall maintain a close working relationship with the State during the certification phase of FMMIS/DSS.

50.2.7 Staffing Requirements for Electronic Health Records Development Phase

50.2.7.1 Minimum Numbers of Categorized Staff

The proposed management staff must be available to the project on a full-time basis. Their sole responsibility during this phase will be to design and implement the requirements for Electronic Health Records (EHR). Any proposed changes to the management staff after contract execution must have prior approval by the State.

1. One (1) EHR Project Manager;
2. One (1) EHR Project Management Professional. This person may be the same as the EHR Project Manager, if the EHR Project Manager is PMP certified and if all RFP requirements can be met without dedicating additional PMP resources; and
3. One (1) EHR Project Management Specialist.

50.2.7.2 Sufficient Numbers of Categorized Staff

The Contractor will provide sufficient supporting staff to carry out all EHR Project functions.

50.2.8 Staffing Requirements for MITA Gap Analysis Phase

50.2.8.1 Minimum Numbers of Categorized Staff

The proposed management staff must be available to the project on a full-time basis. Their sole responsibility will be to perform all responsibilities required to complete the Medicaid Information Technology Architecture (MITA) Gap Analysis. Any proposed changes to the management staff after contract execution must have prior approval by the State.

1. One (1) MITA Gap Analysis Manager;
2. One (1) MITA Project Management Professional. This person may be the same as the MITA Gap Analysis Manager, if the MITA Gap Analysis Manager is PMP certified and if all RFP requirements can be met without dedicating additional PMP resources; and
3. One (1) MITA Project Management Specialist.

50.2.8.2 Sufficient Numbers of Categorized Staff

The Contractor must provide sufficient supporting staff to carry out all MITA Gap Analysis requirements.

50.2.9 Staffing Requirements for Turnover Phase

50.2.9.1 Minimum Numbers of Categorized Staff

1. One (1) Turnover Manager – This individual must have five (5) years of management for government or private sector health care payor, including a minimum of three (3) years MMIS experience. A bachelor's degree in business management or a related field is required; and
2. One (1) Turnover Project Management Specialist

50.2.9.2 Sufficient Numbers of Categorized Staff

The Contractor must provide sufficient supporting staff to carry out all turnover requirements. Such staff must be over and above any staff required to maintain continued operations through the end of the Operations Phase.

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50.3 Facility Requirements

50.3.1 Communication Requirements (Design and Development)

The Contractor must develop or use a Commercial-Off-The Shelf (COTS) correspondence management system to manage official correspondence between the Contractor and the State. The system should be Web-based and conform to FMMIS/DSS architecture standards. All written and official electronic correspondence between the Implementation Team Leader and the Contractor must be logged, archived and maintained by the Contractor for seven years beyond the term of the contract and any extensions of the contract. The Contractor must provide the State with electronic access to this correspondence, including access to images of all written correspondence.

The State will assign a full-time Implementation Team Leader to provide overall project direction and to act as liaison between the Contractor and the State. The Implementation Team Leader will be the chief point for all communications with the State. The Contractor must designate an onsite Project Manager to act as the chief point for all communications with the Contractor.

The Implementation Team Leader will also monitor the Contractor's compliance with the approved work schedule and performance of the Contractor's responsibilities for each task. The Implementation Team Leader will monitor the progress of all tasks according to all approved Work Breakdown Structures (WBS) submitted by the Contractor.

50.3.2 Meeting Room Requirements for Design and Development

The Contractor must supply adequate meeting room facilities to accommodate its key staff and up to twelve (12) State Implementation Team members in regular status and strategy meetings.

The meeting room must have a computer and projector for displaying Internet-based and Windows™ PowerPoint presentations, and a high-quality speakerphone for multiple remote staff to attend meetings by telephone.

50.3.2.1 Location of Operations Facilities

The Contractor’s local facility shall be located within a five (5) mile radius of the State offices located at 2727 Mahan Drive, Tallahassee, Florida. The Agency prefers a location convenient to the Agency and will consider the location in the evaluation process. Consideration of potential expansion of operations should be given in choosing a site for the facility.

The following Contractor functions will be performed at its local Tallahassee facility:

1. Auditing (except for audits performed at provider sites);
2. Business operations;
3. Claims receipt (hard copy) and pre-screening;
4. Mail room;
5. Data entry;
6. Imaging operations;
7. Exception claims processing;

8. All call center operations;
9. Provider check printing;
10. Provider enrollment and re-enrollment;
11. Provider relations (excluding provider field representatives);
12. State liaison; and
13. Systems development and programming.

The Agency will sublease the space from the Contractor at fair market price. The first year not to exceed $18.50 a square foot for Class A property and $16.00 a square foot for Class B property. If the cost of the leased space is less than the rates quoted, it is not to exceed the cost to the Contractor regardless of the building class (no profit or overhead is to be added to the cost of the leased space for any purpose). The Contractor will not increase the cost of the lease agreement without documented increased costs to the Contractor and will limit the increases to no more than 2% of the above quoted rates per year. The Contractor will lease co-located office space in the amount of approximately 12,519 square feet for use by the State. The lease will be a full-service lease, which includes, but not limited to the following: Utilities: power, electrical usage, gas, water, lighting, heat, air conditioning, scheduled janitorial services, routine building maintenance, etc., of Agency space.

The Contractor will include build out costs for space that will accommodate approximately fifty-six (56) personnel with associated spaces (i.e., storage, conference rooms, rest rooms, kitchen to include counter top, sink, and room for a refrigerator and table). The office space will be built-out (not cubicle) and will be designed by the Agency. The following chart represents the approximate space requirements and room size for the staff offices and associated spaces based on the Department of Management Services guidelines. The facility requirements in this section are subject to change during the Design and Development Phase.

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Space Description	Number of Proposed Rooms	Total Square Feet
Executive (225 sq. ft.)	1	225
Administrator (150 sq. ft.)	9	1,350
Manager and Professional (100 sq. ft.)	46	4,960
Common Space:		
Main Reception Area	1	200
Interview Rooms	1	250
LAN Room (1 per Suite or Floor)	1	150
Open Files (6 lin.ft./person/12 lin.ft./file)		153
Pantry (1 per 60 employees)	1	200
Copy (1 per 60 employees	1	200
Conference/Meetings:		
Conference Room (6-8 Person)	1	250
Circulation (40% net usable area)	2	2,731
Special Needs Space:		
Mail Room	1	200
Records Storage	1	200
Central Document Storage and Processing	1	200
Copy/Reproduction Center	1	200
Conference Center	1	350
Library	1	200
IT Storage/Receiving/Workrooms	1	200
Circulation (30% net usable area)		600
Total Square Feet:		**12,519**

The Contractor will provide office furniture for Agency staff at a cost of up to $200,000. Furniture selection is subject to Agency approval. The furniture will become property of the State at the end of the contract. The expense will not be treated as a pass-through item.

Agency parking space will be designated and within easy access to Medicaid Contract Management offices. The Contractor will furnish a minimum of 56 employee, 5 visitor, and 3 handicap parking spaces for the lessee's use. Parking (for both the Contractor and the State) will be designated and reserved. Handicap parking must meet all State requirements for number and design. If parking is mixed with other tenants the Medicaid Contract Management space must be reserved with bumpers and numbered (with letters AHCA, RESERVED, 2102 etc.).

Phone lines, electrical distribution, and computer network system designs will be provided once location and space allocation is determined. The Contractor will be responsible for the acquisition of the entire infrastructure necessary to supply the State leased space with electrical, phone service and computer network services,

including Internet access. The Contractor must provide telephone wiring, cabling, jacks and climate-controlled space for telephone switches. The State will provide telephone instruments for State staff and provide its own, separate monthly telephone service. The Agency Computer and Telephone Cable System and Power Supply Specifications standards are to be adhered to and are provided in Medicaid Procurement Library. Coordination of the Agency IT department will be required during the set-up of the office and operational phase.

All OSHA, environmental impact and fire code requirements will be observed. The Agency expects adequate security and safeguards to be provided by the Contractor to protect State and contract employees from harm. These measures should include, but are not limited to, 1) additional lighting, 2) night time and weekend security patrols, 3) Security Access Reader Card System with magnetic locks, Request to Exit Devices, Sounders, etc. to make the system complete (such as GA-FL or Sonitrol Security System provides), and 4) outside surveillance cameras.

An example of a State RFP for leased space that includes State regulations and specifications for space to be leased to the State is included in the Medicaid Procurement Library.

50.3.3 Communication Requirements (Operations)

The State will assign a full-time Contract Manager to provide overall project direction and to act as liaison between the Contractor and the State. The Contract Manager will be the chief point of contact for all communications with the State. The Contractor must designate an onsite Project Manager to act as the chief point of contact for all communications with the Contractor.

The Contractor must develop or use a COTS correspondence management system to manage official correspondence between the Contractor and the State. The system should be Web-based and conform to FMMIS/DSS architecture standards. All written and official electronic correspondence between the Contract Manager and the Contractor must be logged, archived and maintained by the Contractor for seven years beyond the term of the contract and any extensions of the contract. The Contractor must provide the State with electronic access to this correspondence, including access to images of all written correspondence.

The Contract Manager will also monitor the Contractor's compliance with the approved work schedule and performance of the Contractor's responsibilities for each task. The Contract Manager will monitor the progress of all tasks according to all approved Work Breakdown Structures (WBS) submitted by the Contractor.

50.3.4 Space Provided for File and Archive Storage

The Contractor will provide space for archiving all paper documents, based on the retention periods set by the State for each type of document.

In addition, the Contractor will provide an additional one thousand (1,000) square feet of secure, climate-controlled, onsite storage for long-term care facility files and other documents, with access restricted to approved State staff only, as designated by the State.

50.3.5 State Access to Processing Facilities and Contractor Staff

The Contractor will provide twenty-four-hours, seven-days-a-week access to all Tallahassee, Florida, FMMIS/DSS facilities and operations to each Medicaid employee designated by the State, without prior notice, admission, escort, or other requirements. The State and the Contractor will establish appropriate protocols to ensure that physical property/facility security and data confidentiality safeguards are maintained. Access to any non-Tallahassee facility used to support FMMIS/DSS will be granted within five (5) workdays of the request.

50.3.5.1 Computer Resources

FMMIS/DSS computer processing will be performed at a site to be selected by the Contractor and approved by the State.

The Contractor will be responsible for providing computer resources to support the completion of all tasks. No State computer resources will be available to the Contractor except those necessary to transmit eligibility data and those that may be necessary to test system interfaces during the design, development, implementation planning, and acceptance testing tasks. Contractor computer resources must be available 24-hours-a-day, seven-days-a-week, except for authorized down time and maintenance.

The Contractor will be responsible for providing and maintaining all necessary telecommunications circuits between the State offices and the Contractor's facilities.

50.3.5.2 Location of Backup and Contingency Facilities

Backup, disaster recovery and contingency facilities will be performed at sites specified in the Contractor’s Continuity of Operations Plan (COOP), subject to State approval. The Contractor will be required to include plans to house State Medicaid Contract Management (MCM) key staff during COOP deployment.

50.3.5.3 Location of System Analysis and Programming Resources

Contractor System Analysis and Programming resources must be located at the Contractor’s local Tallahassee facility, except as approved by the State. Approval for off-site work will be rarely granted by the State.

50.3.5.4 Location of Subcontractors

Subcontractor locations must be approved by the State before operations begin at that location.

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50.4 Project Management

The Contractor must know and actively apply professional project management standards to every aspect of the work performed under this contract. The Contractor must adhere to the highest ethical standards, and exert financial and audit controls and separation of duties consistent with Generally Accepted Accounting Principles (GAAP) and Generally Accepted Auditing Standards (GAAS).

50.4.1 Overview

This contract includes both project-based and operations-based activities, each with its own set of requirements for project management. The Contractor must determine the appropriate level and type of management to successfully complete each requirement of the contract. The following are minimum requirements.

50.4.1.1 PMBOK ®

The Contractor must adhere to the American National Standards Institute (ANSI) and Project Management Institute, Inc. (PMI) principles recorded in the latest version of the Project Management Body of Knowledge (PMBOK ® Guide). At least one member of the Contractor's key staff must be a certified Project Management Professional by PMI or a similar credentialing body not affiliated with the Contractor.

50.4.1.2 Information Technology Iterative Project Management

The Contractor must apply the principles of Capability Maturity Model ® (CMM) or a comparable model for all application development and maintenance.

The Contractor must include in its response to this RFP a description of its application development and maintenance methodology, and identify the approach to:

1. Requirements Management;
2. Project Planning;
3. Project Tracking and Oversight;
4. Subcontractor Management;
5. Quality Assurance;
6. Software Configuration Management;
7. Process Focus;
8. Process Definition;
9. Training;
10. Integrated Software Management;
11. Software Product Engineering; and
12. Peer Reviews.

50.4.1.3 Functional vs. Project Organization

The Contractor must meet different requirements for both its functional responsibilities, those related to day-to-day operations and described generally in Section 40: Technical and Business Process Requirements; and projects, work tasks described in Section 50: Scope of Work, larger Customer Service Requests (CSRs), and other work defined below.

50.4.1.4 Project Thresholds

Any work task undertaken by the Contractor not described in Section 40: Technical and Business Process Requirements and exceeding 15 FTE workdays of work effort will be considered a Project. Small Projects consist of less than 30 FTE workdays effort; Medium Projects consist of 30 to 90 FTE workdays effort; Large Projects exceed 90 FTE workday effort.

Project	Any work task with a defined beginning and end, a defined result, and requiring more than 15 FTE workdays of estimated effort.
Small Project	Any work task with 16 to 29 FTE workdays of estimated effort.
Medium Project	Any work task with 30 to 90 FTE workdays of estimated effort.
Large Project	Any work task with more than 90 FTE workdays of estimated effort.

50.4.1.5 Maintenance of PMO

For each Project, the Contractor will create a Project Management Office (PMO) and will follow the project management steps described below as appropriate to the size of the project.

50.4.1.6 Separation of Duties

The Contractor must separate functions and segregate duties of personnel to assure adequate financial, security, quality and auditing controls consistent with the size and volume of the Florida Medicaid program and Generally Accepted Accounting Principles (GAAP) and Generally Accepted Auditing Standards (GAAS).

Financial Control

The Contractor must operate its banking unit under separate management from its claims, computer operations and security units. Individuals in the same family may not work in any combination of the following: Provider Communications (call-center), Provider Enrollment, Banking, Finance, Audit, and Systems Security. Appropriate separation of duties must be applied to all aspects of financial management.

Security

The Contractor must operate a Systems Security unit under direct management control. The Contractor must separate duties of staff responsible for network connections, routing, firewall management, intrusion detection, email service, user authentication and verification, password management, and physical access control to ensure appropriate administrative, physical and technical controls are in place.

Quality Control

The Contractor must operate a Quality Monitoring and Control unit under direct management control. Staff in this unit may not participate in the day-to-day operations they are monitoring.

50.4.2 Functional Management Requirements (for General Operations)

50.4.2.1 Reporting Status of Operations (Automated Status Reporting)

The Contractor must develop or use a COTS system for reporting the status of operations to the State. The system must allow the State to identify items for monitoring. Items may relate to automated operations (such as the number of Web-based claims received, approved, suspended and denied each day) or may require some manual input (such as the number of correct responses in a quality monitoring of 100 call-center inquiries). Initial items for inclusion in the automated status reporting system are described in Section 40.5.3, Management Reporting. Automated items must be reported in real time.

50.4.2.2 Reporting Exceptions

The Automated Status Reporting function must allow the State to determine acceptable parameters of operation (such as adjudicating all Web-based claims within two hours of receipt, or completing 80 percent of provider enrollments within thirty days of initial submission of an application). The system must automatically detect exceptions and notify appropriate State staff by email when an exception occurs.

50.4.2.3 Reporting Staff Levels

The Contractor must provide an updated organizational chart to the State within fifteen (15) calendar days of the beginning of each quarter. All personnel must be listed by name and position.

The Contractor must develop or use a COTS package to record staff work in each operational area and on each project. The Contractor must provide access to this system for inquiry purposes, and must produce detail reports at the State's request.

50.4.2.4 Quality Control

The Contractor must maintain an independent quality control unit. This unit will conduct monitoring surveys and be responsible to record information on operations as part of the Automated Status Reporting function.

50.4.3 Project Management Requirements (for Projects)

50.4.3.1 Project Charter

The Contractor must provide a Project Charter for all projects. The charter must include: Title of the Project, Name of the Project Manager, Result/Product of the Project, Authority of the Project Manager, Constraints, Assumptions, Executing Authority (approval of management), and Date approved.

50.4.3.2 Stakeholder Analysis

The Contractor must provide a stakeholder analysis for all Medium and Large Projects.

50.4.3.3 Communication Management

The Contractor must provide a Communications Management Plan for all Projects. Early in the Project, the Contractor will determine all State communications needs, including status reporting and project monitoring, and create a process to meet those needs. During the project, the Contractor will execute the plan, usually with formal weekly status reports in formats approved by the State. At the end of the project, the Contractor will meet with the State to receive quality improvement feedback, and will record lessons learned for use in future Projects.

50.4.3.4 Scope Management

Early in every Project, the Contractor will perform scope planning and scope definition tasks to result in a Work Breakdown Structure (WBS), known informally as the “Project Plan” and known in previous implementation contracts as a “Detailed Implementation Plan” (DIP). This WBS must identify and record all major tasks, milestones and deliverables associated with the Project. The work must be decomposed into tasks that allow for accurate estimation of the work and resources required to complete the Project. Any task that requires more than 80 hours or 10 workdays to complete must be further decomposed. During execution of the Project, the Contractor must measure performance according to the WBS and manage changes to the plan requested by the State. When tasks are complete, the Contractor must seek verbal acceptance from the State for each task, and formal acceptance of each deliverable.

50.4.3.5 Risk Management

1. The Contractor must develop and use a standard Risk Management Plan approved by the State for all Medium and Large Projects. The plan must address the process and timing for risk identification, describe the process for tracking and monitoring risks, identify the Contractor staff that will be involved in the risk management process, identify the tools and techniques that will be used in risk identification and analysis, describe how risks will be quantified and qualified, and how the Contractor will perform risk response planning.
2. Early in the initiation of Medium and Large Projects, the Contractor must use the standard Risk Management Plan as approved by the State, producing lists of identified risks. For each risk, the Contractor must evaluate and set the risk priority based on likelihood and impact, assign risk management responsibility,

and create a risk management strategy. For each significant accepted risk, the Contractor must develop risk mitigation strategies to limit the impact.

3. The Risk Management Plan must include aggressive monitoring for risks, identify the frequency of risk reports, and describe the plan for timely notification to the State of any changes in risk or trigger of risk events.

50.4.3.6 Cost Management

Early in every Project, the Contractor must determine the resources necessary to complete the Project in a timely and efficient manner, and must estimate and budget for costs, and post these estimates to each task in the WBS. Although in most cases the costs will not be chargeable to the State, the estimate will be used by the State for planning and setting priorities, and will be used by the State and the Contractor to report cost variance. During execution of the Project, the Contractor must regularly report cost variance at the task level, based on the percentage completion of the task and the actual number of hours or days worked on the task.

50.4.3.7 Quality Management

For each Large Project, the Contractor must employ a formal Quality Management Plan. Early in the Project, the Contractor must develop checklists, measures and tools to measure the level of quality of each deliverable. The quality measurement process applies to plans and documents, as well as programs and operational functions. The Quality Management plan must reflect a process for sampling and audits and for continuous quality improvement.

50.4.3.8 Staffing Management

For all Projects, the Contractor must create a Staffing Management Plan, including organizational charts with defined responsibilities and contact information. Resources must be allocated by name or by type to the WBS. During Project execution, the Contractor must provide appropriate training and management supervision to all staff.

50.4.3.9 Time Management

For all Projects, the Contractor must create a Project Schedule. The Project Schedule must include duration estimates for each task in the WBS; the sequence of tasks, including identification of the critical path; and the method to be used by the Contractor to control time spent on the Project.

50.4.3.10 Project Execution and Control

During execution of every Project, the Contractor must exert control to assure the completion of all tasks according to the Project Schedule and Project Budget. All variances must be reported to the State, and the Contractor must work with the State to deal with any variance in a manner that will assure overall completion of the Project within time and budget constraints. The State will work with the Contractor to approve fast-tracking or reallocation of Contractor resources as necessary.

50.4.3.11 Integrated Management

All requirements for project management are interrelated. The Contractor may apply integrated project management tools or COTS products to consolidate reports

required for the management of Projects. The Contractor must execute careful change control on every Project.

50.4.3.12 Status Reporting

1. For all projects, the Contractor must prepare written status reports and attend status meetings on a schedule approved by the State. Except as otherwise approved, status meetings will be held on a weekly basis;
2. Before each status meeting, the Contractor will prepare in formats approved by the State:
   a. A general status report;
   b. Activities completed in the preceding period;
   c. Activities planned for the next period;
   d. A report on issues that need to be resolved;
   e. A report on the status of risks, with special emphasis on change in risks, risk triggers, or the occurrence of risk items;
   f. A report on the status of each task in the WBS that is in progress or overdue;
   g. A cost variance report showing the planned value of the work completed to date, the actual cost of the work completed to date and the variance; and
   h. A schedule variance report showing the earned value of the work completed, the planned value of the work completed, and the variance.
3. Monthly and Quarterly Status reports will summarize data from the weekly reports, include financial information related to expenses and billings for the project, and include executive summaries for presentation to management and oversight bodies. The format for these reports shall be at the direction of the State.

50.4.3.13 Project Management Requirements Summary

Deliverable	Contents	Small Project	Medium Project	Large Project
Project Charter	• Title of Project • Name of the Project Manager • Authority of the Project Manager • Result/Product of the Project • Constraints • Assumptions • Executing Authority • Date Approved	X	X	X
Stakeholder Analysis	• Identification of stakeholders • Stakeholder role/ interests/expectations • Stakeholder contact information		X	X

Deliverable	Contents	Small Project	Medium Project	Large Project
Communications Management Plan	• Feedback loops • Method and frequency of reports for each stakeholder • Project contact list • Frequency of meetings and Status Reports	X	X	X
Work Breakdown Structure (WBS)	• Identify all tasks, deliverables and milestones. • Start date, end date, and work effort for all tasks. • Task dependencies • Resource allocation by task and role • Decompose so no task has estimated work effort more than 160 hours.	X	X	X
Risk Management Plan	• Identification of risks • Process for tracking and monitoring risks • Risk management contractor staff • Tools and techniques used to identify risks • Schedule for assessment of risks • Assignment of risk management responsibility		X	X
Quality Management Plan	• Checklists, measures, and tools used to measure quality • Process for sampling and auditing for quality improvement			X
Staffing Management Plan	• Organizational charts • Defined responsibilities of staff • Staff schedules • Staff contact information		X	X
Project Schedule	• Task duration estimates • Task sequence • Critical path identification • Time control methods	X	X	X

Deliverable	Contents	Small Project	Medium Project	Large Project
Requirements Analysis Document	• Executive Summary • Overview of all processes • Overview and purpose of all interfaces • Discussion of the design implications for each major element of the project • System designs or modifications necessary to complete the project • General report definitions • General screen definitions • Process overview • System behavior model (user interfaces-free form) • High-level flowcharts		X	X
Business Design Document	• Purpose and general business description of each program, module, screen, process, and report • Lists of inputs, outputs and interfaces • Process flowcharts • General resource requirements		X	X
Technical Design Document	• Hardware and software requirements • Program, screen and report specifications sufficient to begin programming and construction • Prototypes • Pseudo-code • Database design or change specifications • Data conversion and interface requirements		X	X
Project Status Reporting: Weekly Monthly Quarterly	• General status report • Completed activities • Planned activities • Project issues • Risk status • Cost variance report • Schedule variance report • Financial information • Executive summaries	X	X	X

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60 PROPOSAL INSTRUCTIONS

60.1 Introduction

A Vendor's proposal shall conform to the following requirements and be prepared according to the instructions in this section.

A Vendor shall submit its Technical Proposal (one original and twelve copies) and its Cost Proposal (one original and five copies) in two separately sealed packages.

See Section 20.13 for complete instructions for submitting proposals to AHCA.

60.2 Technical Proposal Instructions

The Technical Proposal shall include the following sections separated by tabs.

Tab 1	Required Forms
Tab 2	Title Page and Summary
Tab 3	Proposal Guarantee
Tab 4	Corporate Background and Experience
Tab 5	Project Management
Tab 6	Technical Approach to Design and Development
Tab 7	Technical Approach to Implementation Planning
Tab 8	Technical Approach to Implementation
Tab 9	Technical Approach to Operations
Tab 10	Technical Approach to MMIS Certification
Tab 11	Technical Approach to Electronic Health Records
Tab 12	Technical Approach to MITA Gap Analysis
Tab 13	Technical Approach to Turnover
Tab 14	Data Processing
Tab 15	Performance Bond

60.2.1 TAB 1 – Required Forms

Tab 1 of the proposal shall be labeled **Required Forms** and shall include the signed forms required in this RFP. As appropriate, these forms shall include original signatures of an individual authorized to legally bind the Vendor.

These forms include:

1. Business Associate Agreement (Attachment B)
2. Certification Regarding Debarment (Attachment C)
3. Certification Regarding Lobbying (Attachment D)
4. Certificate of Compliance (Attachment E)

5. Statement of No Involvement (Attachment F)
6. Statement of Drug Free Workplace (Attachment G)
7. Corporate Correspondence Individual (Attachment H)
8. Corporate Reference Form (Attachment I)
9. Personal Reference Form (Attachment J)
10. Addendum Acknowledgment Form(s) (Attachment K)
11. Subcontractor Utilization Report Form For Commodities/Services (Attachment L)

60.2.2 TAB 2 – Title Page and Summary

Tab 2 shall be labeled **Title Page and Summary** and shall include the following information:

1. Title Page:
   a. RFP number;
   b. Title of proposal;
   c. Vendor's name;
   d. Organization to which proposal is submitted;
   e. Name, title, phone number, fax number, mailing address and email address of the person who can respond to inquiries regarding the proposal; and
   f. Name of project director.
2. Transmittal Letter:

   The transmittal letter shall be on official business letterhead and signed by an individual authorized to legally bind the Vendor. A copy of the transmittal letter shall be included in each copy of the Technical Proposal. The transmittal letter shall include:

   a. A statement that the Vendor will comply with all terms and conditions as indicated in form PUR 1000, the RFP, and the standard contract included in Attachment A of the RFP;
   b. A statement that the Vendor acknowledges and understands that alternative or contingent proposals will not be accepted.
   c. A statement indicating that the Vendor is a corporation or other legal entity. All subcontractors should be identified, and a statement included indicating the exact amount of work to be completed by the Prime Contractor and each subcontractor. The Technical Proposal must not include actual price information. Such inclusion will result in rejection of the proposal;
   d. A statement confirming that the Prime Contractor is registered to do business in Florida and providing the corporate charter number and assurances that any subcontractor proposed is also licensed to work in Florida;
   e. A statement identifying the Vendor's federal tax identification number;
   f. A statement that no attempt has been made or will be made by the Vendor to induce any other person or firm to submit or not to submit a proposal;

g. A statement of affirmative action that the Vendor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

h. A statement that no cost or pricing information has been included in this letter or the Technical Proposal;

i. A statement identifying all addenda to this RFP issued by the State and received by the Vendor. If no addenda have been received, a statement to that effect shall be included;

j. A statement that the Vendor certifies in connection with this procurement that:

(1) The prices proposed have been arrived at independently, without consultation, communication, or agreement, as to any matter relating to such prices with any other Vendor or with any competitor for the purpose of restricting competition; and

(2) Unless otherwise required by law, the prices quoted have not been knowingly disclosed by the Vendor prior to award, directly or indirectly, to any other Vendor or to any competitor.

(a) A statement that the person signing this letter certifies that he/she is the person in the Vendor's organization responsible for, or authorized to make, decisions regarding the prices quoted and that he/she has not participated, and will not participate, in any action contrary to item (1) above; and

(b) If the use of subcontractor(s) is proposed, a statement from each subcontractor on their letterhead must be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor stating:

- The general scope of work to be performed by the subcontractor;
- The subcontractor's willingness to perform the work indicated; and
- The subcontractor's assertion that it does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex marital status, political affiliation, national origin, or handicap.

3. Executive Summary:

The proposal shall be responsive to all requirements of the RFP and include a beginning narrative containing information that indicates an understanding of the overall need for and purpose of the project as presented in the RFP. Vendors should include in the executive summary a list of suggested Vendor operation locations from which the State will select for a site visit in the evaluation phase. Refer to Section 70.4 for more information regarding the site visit.

60.2.3 TAB 3 – Proposal Guarantee

Tab 3 shall be labeled **Proposal Guarantee** and shall contain the proposal guarantee as follows:

1. Each Vendor's original copy of the Technical Proposal shall be accompanied by a proposal guarantee in the form of a cashier's check, certified check, bank draft, treasurer's check, or guarantee payable to the State in the amount of five hundred thousand dollars ($500,000); and
2. Photocopies of the guarantee are to be inserted at Tab 3 in all other copies of the Technical Proposal submitted by the Vendor.

60.2.4 TAB 4 – Corporate Background and Experience

Tab 4 shall be labeled **Corporate Background and Experience** and include the corporate background and experience for the Vendor and each subcontractor (if any); details of the background of the company, its size and resources, details of corporate experience relevant to the proposed fiscal agent contract, financial statements, and a list of all current or recent Medicaid or related projects. The specific role of any subcontractor must be identified.

The proposal shall include evidence of the Vendor's and subcontractor's capability by describing its organizational background and experience to include:

1. Corporate Background:

   Background information of the corporation, its size, and resources shall cover:

   a. Name of Vendor or subcontractor;
   b. Date established;
   c. Ownership (public company, partnership, subsidiary, etc.);
   d. Corporation's Federal Employer's Identification Number (FEIN) and Florida Corporate Charter Number;
   e. Corporation's primary line of business;
   f. Total number of employees;
   g. Number of personnel engaged in computer systems development and operations;
   h. Number of personnel engaged in MMIS and DSS systems development and operation; and
   i. Computer resources.

2. Corporate Financial Statements:

   Audited financial statements for the legal contracting entity (and parent company if applicable) and subcontractors, sufficient to demonstrate the capability to perform this contract, shall be provided for each of the last three fiscal years.

   These shall include:

   a. Balance sheets;

b. Statement of income;

c. Statements of changes in financial position;

d. Auditor's reports;

e. Notes to financial statements; and

f. Summary of significant accounting policies.

If all of these are not provided, please explain why.

3. Corporate Experience:

   The details of corporate experience, to include all Medicaid contracts (including subcontractors), within the last five (5) years, relevant to the proposed fiscal agent contract shall cover:

   a. Experience with large-scale data processing system development (medical claims, MMIS, DSS or otherwise);

   b. Experience with the operation of a large-scale data processing system (medical claims, MMIS, DSS or otherwise);

   c. Experience with MMIS/DSS (indicate clearly which projects demonstrate experience with system design and development, implementation, operation, modification, certification, or turnover);

   d. Experience with multiple benefit plan administration;

   e. Experience with Web portal development and operations;

   f. Experience with encounter data;

   g. Experience with Prescription Benefit Management (PBM) and other benefit management plan development and operations;

   h. Experience with Decision Support System (DSS);

   i. Experience working directly with managed care providers, HMOs, etc;

   j. Experience as a fiscal agent or fiscal intermediary; and

   k. Experience with other health care systems.

4. Corporate References:

   For each referenced project, the Vendor and subcontractors shall provide the following items, one project per page (Attachment I should be included in proposal Tab 1.):

   a. Name of Vendor

   b. Reference

   c. Firm/Agency Name

   d. Address

   e. Contact Person

   f. Name/Title

   g. Phone Number

   h. Project Dates

i. Title of the Project

j. Start and End Dates of the Original Contract

k. Total Contract Value

l. Average Staff Hours in FTEs During Operations

m. Transaction Processing Volume

n. Brief Description of Scope of Work

60.2.5 TAB 5 – Overall Technical Approach

Tab 5 shall be labeled **Overall Technical Approach** and include the Vendor's overall technical approach to the items listed below for each aspect and phase of this contract. The response in this Tab must cover the Vendor's overall technical approach to the requirements specified in this section, at a minimum:

1. Discuss the Vendor's general approach to address the requirements in Section 30 as follows:
   a. Federal Certification;
   b. Cost Allocation Plan;
   c. Transparency of Subcontractor Relationships;
   d. State Ownership;
   e. Contract Amendments;
   f. Contractor Personnel;
   g. Payment for System Modifications;
   h. System Warranty;
   i. Performance Monitoring;
   j. Record Retention Requirements;
   k. Banking Services;
   l. Telecommunication Requirements and State Owned Equipment;
   m. Access to Libraries;
   n. Accounting;
   o. Minority Participation Reporting;
   p. Force Majeure;
   q. Environmental Considerations; and
   r. HIPAA Compliance;
2. Discuss the Vendor's general approach to address the Contract Phases described in Section 50.1 according to the State's priorities.

3. Discuss the Vendor's general approach to address the requirements in Section 50.4, Project Management:
   a. PMBOK®;
   b. Information Technology Iterative Project Management;
   c. Functional vs. Project Organization;
   d. Authority of Project Manager;
   e. Project Thresholds;
   f. Maintenance of PMO;
   g. Separation of Duties:
      (1) Financial Control;
      (2) Security; and
      (3) Quality Control;
   h. Functional Management Requirements (for General Operations):
      (1) Reporting Status of Operations (Automated Status Reporting);
      (2) Reporting Exceptions;
      (3) Reporting Staff Levels;
      (4) Named Staff Acquisition, Termination, Transfer; and
      (5) Quality Control;
   i. Project Management Requirements (for Projects):
      (1) Project Charter;
      (2) Stakeholder Analysis;
      (3) Communication Management;
      (4) Scope Management;
      (5) Risk Management;
      (6) Cost Management;
      (7) Quality Management;
      (8) Staffing Management;
      (9) Time Management;
      (10) Project Execution and Control;
      (11) Integrated Management; and
      (12) Status Reporting.

60.2.6 Technical Approach Instructions

Each phase of the contract is described in Tabs 6 through 13, which contain the Vendors approach to the technical requirements of this RFP. For each phase the Vendor must fully describe the following:

1. Details of the Vendor's approach to Project Management specific to each phase of the contract shall be included in Tabs 6 through 13. These details shall cover:
   a. Project management approach for each phase;
   b. Authority of project manager for each phase;
   c. Project control approach, including reporting to the State;
   d. Work hours and time estimating methods;
   e. Sign-off procedures and internal quality control for completion of all deliverables and major activities;
   f. Assessment of project risks and anticipated problem areas and Vendor's approach to managing them;
   g. Approach to routine problem identification and resolution;
   h. Interfaces with the State;
   i. Approach to Quality Control;
   j. Assumptions and constraints associated with the phase; and
   k. Use of walk-throughs for each major task.
2. The Vendor shall include a work plan and a schedule for the performance of each phase in Tabs 6 through 13. The schedule must include State tasks and allow adequate time for State approval of each deliverable. The Agency expects the Vendor to provide a detailed work plan produced in Microsoft Project that will track deliverables, tasks, milestones and resources. Additionally, the Contractor will be expected to participate in detailed project management meetings that will report the status of deliverables, tasks, milestones, resources, project risks, and action items for the entire contract start-up process. The work plan and schedule must include each of the following:
   a. Any assumptions or constraints identified by the Vendor, both in developing and completing the work plan;
   b. Person weeks of effort (in maximum of two-week units) for each sub-task, showing Contractor and State personnel efforts separately;
   c. A critical path method (CPM) diagram indicating the interrelationships between sub-tasks; and a Gantt chart, showing the planned start and end dates of all sub-tasks;
   d. A discussion of how the work plan provides for handling of potential and actual problems;
   e. A schedule for all deliverables providing adequate review time by the State, revision time if needed, and subsequent review time; and
   f. Since the RFP is organized by business areas, it is a requirement that system design activities be organized by business area to facilitate requirements traceability and to simplify State resource availability.
3. Technical approach to the phases:

   In preparing the response to Tabs 6 through 13 the Vendor shall not simply provide statements that the requirements of the RFP will be met. Vendors must respond

concisely but fully with their approach and how they will comply with the requirements the RFP. The Vendor must respond to all of the requirements in the RFP, explaining their technical approach, identifying tools to be used, describing staffing commitments and explaining in detail how they will meet all requirements, as they apply to each phase.

Vendors should assemble the best overall solution to each major task required to design, develop, and operate the FMMIS and DSS. To that end, Vendors are encouraged to enter into partnerships with firms that have the greatest expertise and most innovative solutions for the major components of the system, e.g., DSS, PBM, system design, and development etc., and describe how the partners are integrated into a seamless solution.

Vendors should address their use of Commercial-Off-The-Shelf (COTS) products and Web-based solutions, as appropriate in each of the phases.

4. Project Organization and Staffing:

   Include the project organization and staffing for each phase for the Vendor and each subcontractor (if any): project team organization charts of proposed personnel, the number of FTE proposed, and resumes of all staff specified in Section 50.2.

   a. Organizational Charts:

      Proposals shall specify the number of experienced staff that will be working on each phase of this project and describe the organizational structure. The organizational charts shall include:

      (1) All proposed individuals for whom resumes are included, identifying their major areas of responsibility during each task, percent of time dedicated to the FMMIS/DSS and location where work will be performed; and

      (2) Total number FTE personnel for each unit, by staff level, for each unit of staff shown on the organizational chart.

   b. Resumes:

      Individual resumes must be supplied for the named management positions identified in each phase. The appropriate resumes for other professionals must be supplied at the State's request. Resumes must show employment history for all relevant and related experience and all education and degrees (including specific dates, names of employers, and educational institutions). Individuals whose resumes are included in the proposal must be available to work on this contract.

      Individuals proposed for the named positions and other key professional positions must meet the minimum training and experience specified in Section 50.

c. Resume Contents:

The resumes of such personnel proposed shall include:

(1) Experience with Vendor (or subcontractor to Vendor)—list number of years and positions held;

(2) Experience with Medicaid claims processing systems;

(3) Experience with development and operation of large-scale data processing systems;

(4) Project management experience;

(5) Experience with other medical claims processing systems;

(6) Other data processing experience;

(7) Relevant education and training, including college degrees, dates and institution name and location;

(8) Names, positions, and phone numbers of a minimum of three clients, within the past five (5) years who can give information on the individual's experience and competence. (Attachment J should be included in Tab 1.) If the individual has not worked for three different clients in the last five (5) years, provide three references that can give information on the individual's experience and competence. References must not be from employees of the same company; and

(9) Each project listed in a resume must include the following:

(a) Full name, title, and (current) telephone number of a client reference for the last five years, including the current project of the staff person;

(b) Start and end dates of the referenced project;

(c) Position(s) of the individual within the project organization; and

(d) Brief description of the individual's responsibilities.

5. All deliverables and correspondence produced in the execution of this RFP must be clearly labeled with, at a minimum, project name, deliverable title, deliverable tracking or reference number, version number and date.

60.2.7 TAB 6 – Technical Approach to Design and Development

Tab 6 shall be labeled **Technical Approach to Design and Development** and include a detailed discussion of the Vendor's approach to the Design and Development Phase. The response must address these components of the phase:

1. Planning:

   A draft schedule must be included in response to this RFP. See Section 60.2.6 for complete instructions on the details to be covered in the planning and management of the phase;

2. Requirements Analysis:

   a. The Contractor must conduct a thorough Requirements Analysis using steps and producing deliverables as required for Large Projects under Section 50.4; and

b. The Contractor must also produce Requirements Analysis documentation, in formats approved by the State;

3. Business and Technical Design;
4. Comprehensive Testing Plan for Design and Development:
   a. Unit Tests;
   b. Structured Data Tests;
   c. Volume Tests:

      The Contractor must use volume simulating tools and methods, and must include a description of its volume testing plan and schedule in response to this RFP;

   d. Operations Readiness Tests:

      The Contractor must include a description of its operations readiness testing strategy, methodology and schedule in response to this RFP;

   e. Parallel Tests:

      The Contractor must include a description of its parallel testing strategy, methodology and schedule in response to this RFP;

   f. Beta Tests:

      The Contractor must describe its approach to Beta testing in response to this RFP;

   g. User Acceptance Tests:

      The Contractor must describe its approach to User Acceptance Testing in response to this RFP;

   h. Retesting:

      The Contractor is responsible to meet the overall deadlines for this implementation; therefore, the Contractor must include a description of its strategy and methodology for dealing with the situation where unit tests, structured data tests, operation readiness tests or parallel tests fail to produce the desired results in response to this RFP;

5. Risk Analysis and Contingency Planning:

   The State will place special scoring emphasis on the Contractor's control and management of project risks in this phase of the project;

6. Technical Design and Development;
7. Testing Execution;
8. Training for State and Contractor staff;
9. State Acceptance Testing;
10. Contractor Responsibilities;
11. Deliverables Prototypes for each milestone in this phase:
    a. Completion of Planning Activities;
    b. Completion of Requirements Analysis Document;

c. Completion of Business and Technical Design;

d. Completion of Comprehensive Testing Plan;

e. Completion of Design and Development, Start of Readiness Testing Period; and

f. Conclusion of User Acceptance Testing;

12. Prototypes of status and progress reports; and

13. Staffing for Design and Development Phase.

60.2.8 TAB 7 – Technical Approach to Implementation Planning

Tab 7 shall be labeled **Technical Approach to Implementation Planning** and include a detailed discussion of the Vendor's approach to the Implementation Planning Phase. The response must address these components of the phase:

1. Data Conversion:

   a. The Contractor must provide a formal Data Conversion Plan addressing all required elements before Requirements Analysis is complete; and

   b. The Contractor must describe in significant detail its approach to data conversion in response to this RFP;

2. Planning:

   The Contractor must create and submit for State approval a schedule for assumption of all fiscal agent processes and include a draft schedule in response to this RFP. See Section 60.2.6 for complete instructions on the details to be covered in the planning and management of the phase;

3. Requirements Analysis:

   The Contractor must also produce Requirements Analysis documentation, in formats approved by the State;

4. Cooperation with Incumbent;

5. Comprehensive Testing Plan Prior to Contractor Assumption of Incumbent Responsibilities:

   a. Unit Tests;

   b. Structured Data Tests;

   c. Volume Tests:

      The Contractor must use volume simulating tools and methods, and must include a description of its volume testing plan and schedule in response to this RFP;

   d. Operations Readiness Tests:

      The Contractor must include a description of its operations readiness testing strategy, methodology and schedule in response to this RFP;

e. Parallel Tests:

The Contractor must include a description of its parallel testing strategy, methodology and schedule in response to this RFP;

f. Beta Tests:

The Contractor must describe its approach to Beta testing in response to this RFP;

g. User Acceptance Tests:

The Contractor must describe its approach to User Acceptance Testing in response to this RFP;

h. Retesting:

The Contractor must include a description of its strategy and methodology for dealing with the situation where unit tests, structured data tests, operation readiness tests or parallel tests fail to produce the desired results;

6. Risk Analysis and Contingency Planning:

The State will place special scoring emphasis on the Contractors control and management of project risks in this phase of the project;

7. Testing Execution;
8. State Acceptance Testing;
9. Contractor Responsibilities for Implementation Planning Phase;
10. Deliverables Prototypes for each milestone in this phase:
    a. Completion of Planning Activities;
    b. Completion of Requirements Analysis;
    c. Completion of Comprehensive Testing Plan;
    d. Completion of Business and Technical Design;
    e. Completion of Implementation Planning, Start of Readiness Testing Period;
    f. Conclusion of User Acceptance Testing;
11. Prototypes of status and progress reports; and
12. Staffing for Implementation Planning Phase.

60.2.9 TAB 8 – Technical Approach to Implementation

Tab 8 shall be labeled **Technical Approach to Implementation** and include a detailed discussion of the Vendor's approach to the Implementation Phase. In its response to this RFP, the Contractor must include a proposed Implementation Schedule covering the following. See Section 60.2.6 for complete instructions on the details to be covered in the planning and management of the phase.

1. Implementation;

2. Planning:

   The Contractor must create and submit for State approval a schedule for assumption of all fiscal agent processes and include a draft schedule in response to this RFP;

3. Correction and Adjustment Activities;
4. Execution of Contingency Plans;
5. Implementation of all Components;
6. Deliverables Prototypes for each milestone in this phase:
   a. Implementation schedule;
   b. Documentation of implemented components; and
   c. Ongoing status and progress reports; and
7. Staffing for the Implementation Phase, including the transition of staffing from the Design and Development and Implementation Planning Phases into the Operations Phase.

60.2.10 TAB 9 – Technical Approach to Operations

Tab 9 shall be labeled **Technical Approach to Operations** and include a detailed discussion of the Vendor's approach to the Operations Phase. The Contractor must operate FMMIS/DSS and perform all functions described in Section 40 from the date of implementation of each component until each function is turned over to a successor fiscal agent at the end of the contract, including any extensions. Vendors must respond concisely but fully with their approach and how they will comply with the requirements the RFP. The Vendor must respond to all of the requirements in the RFP, explaining their technical approach, identifying tools to be used, describing staffing commitments and explaining in detail how they will meet all requirements. Specifically the Vendor must:

1. Respond in detail to every item in Section 40.1;
2. Acknowledge all information contained in the Overview, State Objectives, Interfaces, Inputs, Outputs and State Responsibilities sections of 40.2 through 40.5;
3. Respond in detail to every item under Contractor Responsibilities in Section 40.2 through 40.5;
4. Complete Appendix O, indicating the level of complexity or modifications necessary to meet the requirements indicated in the matrix;
5. Respond in detail to the Contractor requirements in Sections 50.3, “Facility Requirements”; and
6. Provide the details of staffing for Operations Phase.

60.2.11 TAB 10 – Technical Approach to MMIS Certification

Tab 10 shall be labeled **Technical Approach to MMIS Certification** and include a detailed discussion of the Vendor's approach to the MMIS Certification Phase. The response must address these components of the phase. See Section 60.2.6 for complete instructions on the details to be covered in the planning and management of the phase.

1. Planning:
   a. General Planning with State;
   b. Plan to Demonstrate Fulfillment of Federal Requirements; and
   c. Plan to Demonstrate Functional Equivalence;
2. Meet with Federal and State Certification Team:
   a. Generate Test Results;
   b. Explain and Model System Operations; and
   c. Respond to Questions;
3. System Remediation:
   a. Correction of Items Not Certified; and
   b. Change Control for Certification;
4. Deliverable Prototypes:
   a. Demonstration Plan; and
   b. Status Reports and other project requirements defined in Section 50.4, if remediation is required; and
5. Staffing for MMIS Certification.

60.2.12 TAB 11 – Technical Approach to Electronic Health Records

Tab 11 shall be labeled **Technical Approach to Electronic Health Records** and include a detailed discussion of the Vendor's approach to the Electronic Health Records Phase. The response must address these components of the phase. See Section 60.2.6 for complete instructions on the details to be covered in the planning and management of the phase.

1. Planning;
2. General Planning with the State;
3. Research of Alternative Record Formats for EHR;
4. Research of Alternative Methods to Collect the Required Data;
5. Development of HIPAA Privacy and Security Requirements;
6. Provider/Recipient/Others Outreach Efforts;
7. Deliverable Prototypes:
   a. The Project Work Plan;
   b. Record formats and data collection methods;
   c. Privacy and security standards and protocols; and
   d. Outreach plans;
8. Staffing for EHR.

60.2.13 TAB 12 – Technical Approach to MITA Gap Analysis

Tab 12 shall be labeled **Technical Approach to MITA Gap Analysis** and include a detailed discussion of the Vendor's approach to the MITA Gap Analysis Phase. See Section 60.2.6 for complete instructions on the details to be covered in the planning and management of the phase. The response must address these components of the phase:

1. Planning;
2. Approach to determining current MITA development and incorporating that into the MITA Gap Analysis report and any revisions as required by the State;
3. General Planning with State;
4. Deliverable Prototypes:
    a. Draft Outline of the Report;
    b. Project Work Plan;
    c. Status Reports;
    d. Reports required in the phase; and
5. Staffing Requirements for MITA Gap Analysis.

60.2.14 TAB 13 – Technical Approach to Turnover

Tab 13 shall be labeled **Technical Approach to Turnover** and include a detailed discussion of the Vendor's approach to the Approach to Turnover Phase. See Section 60.2.6 for complete instructions on the details to be covered in the planning and management of the phase. The response must address these components of the phase:

1. Planning:
    a. General Planning with State; and
    b. General Planning with Successor;
2. Develop Turnover Plan;
3. Develop FMMIS/DSS Requirements Statement;
4. Provide Turnover Services:
    a. Cooperation with Successor; and
    b. Turnover of Archived Materials;
5. Contract Closeout Services:
    a. Financial Reconciliation;
    b. Written Assessment of Contract Performance; and
    c. Resolution of Turnover Issues;
6. Approach to Contractor Responsibilities, including:
    a. Contractor staffing;
    b. Contractor facilities;

c. Contractor resources;
d. Turnover of FMMIS/DSS;
e. Turnover of system documentation;
f. Turnover training;
g. Facilitation of successor acceptance testing; and
h. Final turnover of up-to-date system, data, paper files, and documentation; and

7. Staffing for Turnover.

60.2.15 TAB 14 – Data Processing

Tab 14 shall be labeled **Data Processing** and include the following:

1. Description and location of data and fiscal agent operations facility in Tallahassee:
   a. List of local hardware/software; and
   b. List of corporate site hardware/software;
2. Location of:
   a. Computer resources;
   b. Back-up and contingency facilities;
   c. System analyst and programmers resources; and
   d. Subcontractors;
3. Approach to system capacity evaluation and planning to address identified issues;
4. Approach Data Processing Standards covering the following areas:
   a. FMMIS System Architecture Requirements;
   b. DSS System Architecture Requirements;
   c. Software/Hardware Configuration;
   d. FMMIS/DSS Transaction Processing Requirements;
   e. DSS Information Processing Requirements;
   f. Programming Language Requirements;
   g. System Modification and Change Control Requirements;
   h. Application Development and Testing Requirements;
   i. Data Imaging and Data Entry Requirements;
   j. Data Quality Control;
   k. Security and Confidentiality Requirements;
   l. Documentation;
   m. Continuous Business Process Improvement;
   n. State Training Requirements; and
   o. Provider Training Requirements;

5. Approach to the use of COTS and Web-based solutions;
6. Approach to imaging and data entry;
7. Telecommunication network description;
8. Approach to security and confidentiality;
9. Approach to documentation; and
10. Approach to procurement of State hardware.

60.2.16 TAB 15 – Performance Bond

Tab 15 shall be labeled **Performance Bond**. Vendor shall explicitly state agreement to a performance bond of 15% of the average five-year annual operational costs as specified in Section 30.24. No pricing information is to be stated in this Tab, only the Vendor's agreement to supply the performance bond in the amount required.

The remainder of this page intentionally left blank.

60.3 Cost Proposal Instructions

Vendors shall propose a firm fixed price for each of the requirements contained on the pricing schedules within this section. All Pricing Schedules provided in this RFP (Section 60) shall be submitted as part of the Cost Proposal. No cost information shall be included in the Technical Proposal. The requirements and schedules are:

1. Summary of Total Proposal (Pricing Schedule A);
2. FMMIS/DSS Planning, Design, Development, Testing, and Implementation Price Components from Contract Award Through June 30, 2007 (Pricing Schedule B);
3. Net Present Value FMMIS/DSS Planning, Design, Development, Testing, and Implementation Price (Pricing Schedule B-1);
4. Operational Price Summary (Pricing Schedule C);
5. Operational Price Components (Pricing Schedules C1-C5);
6. Net Present Value Operational Price State fiscal years 2007-2008 – 2011-2012 (Pricing Schedule C-6);
7. MITA Gap Analysis Price (Pricing Schedule D);
8. Net Present Value MITA Gap Analysis Price (Pricing Schedule D-1);
9. Electronic Health Record (EHR) Price (Pricing Schedule E); and
10. Net Present Value Electronic Health Record (EHR) Price (Pricing Schedule E-1).

Required formats for the pricing schedules that shall be used by Vendors in preparing their Cost Proposals are included later in this section. Net present value methodology as described in Florida Statutes, Section 287.0572 shall be used in preparing the Cost Proposal.

60.4 General Requirements for the Cost Proposal

60.4.1 Total FMMIS/DSS Planning, Design, Development, Testing, and Implementation Price

The total FMMIS/DSS Planning, Design, Development, Testing, and Implementation from Contract Award through June 30, 2007, price will include the combined sums of all activities to complete RFP Section 40 requirements. The total non-operational price will not exceed $40,000,000.

The Contractor will be paid according to the payment terms in Section 30.27 of this RFP.

60.4.2 Operations Price

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

60.4.3 Signature Block

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

60.4.4 Members Per Month

The Cost Proposal shall be calculated assuming a monthly caseload of 2.2 to 3.0 million members per month. Members are defined as an individual who is Medicaid eligible for a month under one of the eligibility groups listed below. The eligibility groups may vary as defined by the State legislature. The Social Services Estimating Conference monthly report produced by the Agency will define the number of members per month.

- Supplemental Security Income (SSI);
- Temporary Assistance for Needy Families (TANF);
- Medically Needy;
- Expanded Coverage for Children and Pregnant Women;
- Categorically Eligible;
- Elderly and Disabled (MEDS-AD);
- Qualified Medicare Beneficiaries (QMB);
- Silver Saver Program; and
- Refugee General Assistance.

Should the members per month exceed 3.0 million members per month for any given month, the State shall pay the Contractor an additional $1.25 for each member that exceeds 3.0 million.

60.5 Pricing Schedule A - Summary of Total Proposal

1. Line 1 presents the Vendor's Net Present Value price for all FMMIS/DSS Planning, Design, Development, Testing, and Implementation activities.
2. Line 2 presents the Vendor's Net Present Value of Operational Price.
3. Line 3 represents the Net Present Value of MITA Gap Analysis Price.
4. Line 4 represents the Net Present Value of Electronic Health Records (EHR) Price.
5. Line 5 represents the Total Contract Price.

60.6 Pricing Schedule B – FMMIS/DSS Planning, Design, Development, Testing, and Implementation Price Components from Contract Award Through June 30, 2007

Pricing Schedule B shall include the total cost components of FMMIS/DSS Planning, Design, Development, Testing, and Implementation defined in Section 50, from contract award through June 30, 2007.

Instructions for completing Pricing Schedule B:

1. Vendors are required to furnish detailed price information used in deriving the proposed price for each of the categories and subcategories shown on the detailed Pricing

Schedule B. The total price on Pricing Schedule B shall be allocated to Pricing Schedule B-1 using the percentages shown on each line.

2. Vendors are required to indicate the specific number of full-time equivalent personnel in each of the subcategories and the average hourly rate of pay including benefits on Lines 1a-1m. The prices shown on the schedules are to be the total annual salary and benefits necessary for this phase of the contract. The number of specific levels of personnel and their associated prices must agree with the work effort and staffing levels proposed in the Technical Proposal.
3. Telephone prices for equipment and line charges, including toll free lines.
4. If a price category is not already shown on Schedule B, Line 1 through Line 8, Vendors are to indicate the category under the section headed Other, Line 9. Vendors should list any subcontractor amounts under the section headed Other, Line 9.

The total price on Line 10 shall not exceed $40,000,000.

60.7 Pricing Schedule B-1 - Net Present Value FMMIS/DSS Planning, Design, Development, Testing, and Implementation Price

Pricing Schedule B-1 presents the net present value of prices from Schedule B, Price Components. The total of Line 13, Column C must equal the total of Line 10, Pricing Schedule B.

The Vendor shall compute the total FMMIS/DSS Planning, Design, Development, Testing, and Implementation price for each milestone by multiplying the percentages in Column B by the total of Line 10, Pricing Schedule B.

The Total Phase Price for each task in Column C shall be multiplied by the NPV factor in Column D to compute the Total Net Present Value Price.

The Total NPV price from Pricing Schedule B-1, Line 13, Column E shall be entered in Pricing Schedule A, Line 1.

60.8 Pricing Schedules C - Operational Prices

Pricing Schedule C is a summary of prices for all operational costs, presented in the State fiscal years from July 1, 2007, through June 30, 2012, excluding costs for the MITA Gap Analysis and Electronic Health Records (EHR).

60.9 Pricing Schedules C-1 through C-5

Instructions for completing Pricing Schedules C-1 through C-5.

1. Vendors shall propose a firm fixed price per month for the contract period. The monthly price will include all costs associated with the operation of the FMMIS/DSS described in Sections 40 and 50 of this RFP (except pass through costs as described in Section 30). Payment methodology for Contractor services is described in Section 30.27.
2. Vendors are required to furnish detailed price information used in deriving the proposed price per month for each of the categories and subcategories shown on the detailed Pricing Schedules C-1 through C-5. The Total Price This Year, Line 10 on Schedules C-1 through C-5, is to be reported in Line 1, Columns B through F of Pricing Schedule C.

3. Vendors are required to indicate the specific number of full-time equivalent personnel in each of the subcategories and the average hourly rate of pay including benefits on Lines 1a-1m. The prices shown on the schedules are to be the total annual salary and benefits necessary for the operation of the FMMIS/DSS system. The number of specific levels of personnel and their associated prices must agree with the work effort and staffing levels proposed in the Technical Proposal.
4. Telephone prices for equipment and line charges, including toll free lines.
5. If a price category is not already shown on Schedules C-1 through C-5, Line 1 through Line 8, Vendors are to indicate the category under the section headed Other, Line 9. Vendors should list any subcontractor amounts under the section headed Other, Line 9.

60.10 Pricing Schedule C-6- Net Present Value - Operational Price

Pricing Schedule C-6 must include the net present value of the operational price for the entire five (5) year operational phase of the contract period. The Fixed Price Per Month entered in Pricing Schedule C-6, Column B must equal the Average Price Per Month from Pricing Schedule C, Line 2 for each of the respective years. The Vendor must calculate the monthly net present value total. The total amount in Pricing Schedule C-6, Line 61, Column D must be entered into Pricing Schedule A, Line 2.

Below are the details for completing Schedule C-6.

Column A - MONTH - lists the sixty (60) months covered in the operations phase of the contract.

Column B - TOTAL PROPOSED PRICE - must be filled in by the Vendor and must be identical to the year average price per month presented by the Vendor on Pricing Schedule C, Line 2, for each of the respective years.

Column C - NET PRESENT VALUE FACTOR - is supplied by the State.

Column D - TOTAL NET PRESENT VALUE PRICE - the Vendor is to complete this Column by multiplying Column B by Column C.

The total of all sixty months Net Present Value Price will be totaled on Schedule C-6, Line 61 (D) and will be entered in Schedule A, Line 2.

60.11 Pricing Schedule D - MITA Gap Analysis Price

Instructions for completing Pricing Schedule D.

1. Vendors shall propose a firm fixed price for performing the MITA Gap Analysis as described in Section 50.
2. Vendors are required to furnish detailed price information used in deriving the proposed price for each of the categories and subcategories shown on the detailed Pricing Schedule D. The total price on Pricing Schedule D shall be allocated to Pricing Schedule D-1 using the percentages shown on each line.
3. Vendors are required to indicate the specific number of full-time equivalent personnel in each of the subcategories and the average hourly rate of pay including benefits on Lines 1a-1m. The prices shown on the schedules are to be the total annual salary and benefits necessary for this phase of the contract. The number of specific levels of

personnel and their associated prices must agree with the work effort and staffing levels proposed in the Technical Proposal.

4. Telephone prices for equipment and line charges, including toll free lines.
5. If a price category is not already shown on Schedule D, Line 1 through Line 8, Vendors are to indicate the category under the section headed Other, Line 9. Vendors should list any subcontractor amounts under the section headed Other, Line 9.

60.12 Pricing Schedule D-1- Net Present Value - MITA Gap Analysis Price

Below are the details for completing Pricing Schedule D-1.

Column A - MONTH – is supplied by the State.

Column B - TOTAL PROPOSED PRICE FOR MITA GAP ANALYSIS - must be filled in by the Vendor and must be identical price presented by the Vendor on Pricing Schedule D, Line 10.

Column C - NET PRESENT VALUE FACTOR - is supplied by the State.

Column D - TOTAL NET PRESENT VALUE PRICE - the Vendor is to complete this Column by multiplying Column B by Column C. Post this total to Pricing Schedule A, Line 3.

60.13 Pricing Schedule E - Electronic Health Records (EHR)

Instructions for completing Pricing Schedule E.

1. Vendors shall propose a firm fixed price for performing the Electronic Health Records (EHR) as described in Section 50.
2. Vendors are required to furnish detailed price information used in deriving the proposed price for each of the categories and subcategories shown on the detailed Pricing Schedule E. The total price on Pricing Schedule E shall be allocated to Pricing Schedule E-1 using the percentages shown on each line.
3. Vendors are required to indicate the specific number of full-time equivalent personnel in each of the subcategories and the average hourly rate of pay including benefits on Lines 1a-1m. The prices shown on the schedules are to be the total annual salary and benefits necessary for this phase of the contract. The number of specific levels of personnel and their associated prices must agree with the work effort and staffing levels proposed in the Technical Proposal.
4. Telephone prices for equipment and line charges, including toll free lines.
5. If a price category is not already shown on Schedule E, Line 1 through Line 8, Vendors are to indicate the category under the section headed Other, Line 9. Vendors should list any subcontractor amounts under the section headed Other, Line 9.

60.14 Pricing Schedule E-1- Net Present Value - Electronic Health Records (EHR) Price

Below are the details for completing Pricing Schedule E-1.

Column A – MONTH – is supplied by the State.

Column B – PHASE PAYMENT – shows the percentage of the total price to be paid for each phase.

Column C – TOTAL PROPOSED PRICE FOR EHR - must be filled in by the Vendor and the total price must be identical price presented by the Vendor on Pricing Schedule E, Line 10. Multiply the total price by the percentage in Column B to calculate the price per phase.

Column D – NET PRESENT VALUE FACTOR - is supplied by the State.

Column E – TOTAL NET PRESENT VALUE PRICE - the Vendor is to complete this Column by multiplying Column B by Column C. Post this total to Pricing Schedule A, Line 4.

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PRICING SCHEDULE A

SUMMARY OF TOTAL PROPOSAL

1. Net Present Value of FMMIS/DSS System Planning, Design, Development, Testing, and Implementation (Schedule B-1, Line 13, Column E) $_____

2. Net Present Value of Operational Price (Schedule C-6, Line 61, Column D) $_____

3. Net Present Value of MITA Gap Analysis (Schedule D-1, Column D) $_____

4. Net Present Value of Electronic Health Records (EHR) (Schedule E-1, Column E) $_____

5. Total Contract Price $_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE VENDOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

_____

Signature of Corporate Official Title Date

PRICING SCHEDULE B

FMMIS/DSS PLANNING, DESIGN, DEVELOPMENT, TESTING AND IMPLEMENTATION PRICE COMPONENTS FROM CONTRACT AWARD THROUGH JUNE 30, 2007.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

TOTAL PRICE FOR THIS PHASE NOT TO EXCEED $40,000,000.00.

AN AUTHORIZED CORPORATE OFFICIAL OF THE VENDOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE B-1

NET PRESENT VALUE FMMIS/DSS PLANNING, DESIGN, DEVELOPMENT, TESTING AND IMPLEMENTATION PRICE

Net Present Value Discount Rate supplied by Department of Management Services (DMS) = 3.24%

Tasks are shown as a percentage of the total from Pricing Schedule B. The total of Column C must equal the total of Line 10, Pricing Schedule B.

	A	B	C	D	E
#	Month/Year	Milestones	Total Phase Price	NPV Factor	Total Net Present Value Price E = (C*D)
Design and Development Phase					
1	December 2005	Planning (4%)		0.98927251	
2	February 2006	Requirements Analysis (3%)		0.98395199	
3	May 2006	Business and Technical Design (4%)		0.97602483	
4	July 2006	Comprehensive Testing Plan (10%)		0.97077556	
5	February 2007	Development of New System (35%)		0.95262447	
6	June 2007	Acceptance Testing (10%)		0.94240519	
Implementation Planning Phase					
7	December 2005	Planning (4%)		0.98927251	
8	February 2006	Requirements Analysis (3%)		0.98395199	
9	May 2006	Business and Technical Design (4%)		0.97602483	
10	July 2006	Comprehensive Testing Plan (10%)		0.97077556	
11	June 2007	Acceptance Testing (3%)		0.94240519	
Implementation Phase					
12	September 2007	Corrections and Adjustment Activities (10%)		0.93481275	
13	TOTAL				

Post total Line 13 on column E to Schedule A, Line 1.

AN AUTHORIZED CORPORATE OFFICIAL OF THE VENDOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE C

OPERATIONAL PRICE SUMMARY

(A) Price Components	(B) Year 1 (2007-2008)	(C) Year 2 (2008-2009)	(D) Year 3 (2009-2010)	(E) Year 4 (2010-2011)	(F) Year 5 (2011-2012)	(G) Total	(H) Five Year Average
1. Total Price All Components (From C1-C5, Line 10)	$_____	$_____	$_____	$_____	$_____	$_____	
2. Price Per Month (Line 1/12 months)	$_____	$_____	$_____	$_____	$_____		
3. 5 Year Average Price Per Month (Line 1G/60 months)							$_____

Year 1 (2007-2008) Price Per Month – Enter on C-6 Lines 1 - 12, Column B.
Year 2 (2008-2009) Price Per Month – Enter on C-6 Lines 13 - 24, Column B
Year 3 (2009-2010) Price Per Month – Enter on C-6 Lines 25 – 36, Column B
Year 4 (2010-2011) Price Per Month – Enter on C-6 Lines 37 – 48, Column B
Year 5 (2011-2012) Price Per Month – Enter on C-6 Lines 49 – 60, Column B

AN AUTHORIZED CORPORATE OFFICIAL OF THE VENDOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

_____

Signature of Corporate Official Title Date

PRICING SCHEDULE C-1

OPERATIONAL PRICE COMPONENTS FROM JULY 1, 2007 THROUGH JUNE 30, 2008.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE VENDOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE C-2

OPERATIONAL PRICE COMPONENTS FROM JULY 1, 2008 THROUGH JUNE 30, 2009.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE VENDOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE C-3

OPERATIONAL PRICE COMPONENTS FROM JULY 1, 2009 THROUGH JUNE 30, 2010.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE VENDOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE C-4

OPERATIONAL PRICE COMPONENTS FROM JULY 1, 2010 THROUGH JUNE 30, 2011.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE VENDOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE C-5

OPERATIONAL PRICE COMPONENTS FROM JULY 1, 2011 THROUGH JUNE 30, 2012.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE VENDOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE C-6

NET PRESENT VALUE OPERATIONAL PRICE
STATE FISCAL YEARS 2007-2008 – 2011-2012

Net Present Value Discount Rate supplied by Department of Management Services (DMS) = 3.24%

	A	B	C	D
Line #	Month	Total Proposal Price	NPV Factor	Total Net Present Value Price D = (B*C)
1	July 2007	$	0.93986755	$
2	August 2007	$	0.93733674	$
3	September 2007	$	0.93481275	$
4	October 2007	$	0.93229555	$
5	November 2007	$	0.92978513	$
6	December 2007	$	0.92728147	$
7	January 2008	$	0.92478455	$
8	February 2008	$	0.92229436	$
9	March 2008	$	0.91981087	$
10	April 2008	$	0.91733407	$
11	May 2008	$	0.91486393	$
12	June 2008	$	0.91240045	$
13	July 2008	$	0.90994360	$
14	August 2008	$	0.90749337	$
15	September 2008	$	0.90504974	$
16	October 2008	$	0.90261268	$
17	November 2008	$	0.90018219	$
18	December 2008	$	0.89775824	$
19	January 2009	$	0.89534082	$
20	February 2009	$	0.89292991	$
21	March 2009	$	0.89052550	$
22	April 2009	$	0.88812755	$
23	May 2009	$	0.88573606	$
24	June 2009	$	0.88335102	$
25	July 2009	$	0.88097239	$
26	August 2009	$	0.87860017	$
27	September 2009	$	0.87623434	$
28	October 2009	$	0.87387487	$
29	November 2009	$	0.87152177	$
30	December 2009	$	0.86917499	$

AN AUTHORIZED CORPORATE OFFICIAL OF THE VENDOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE C-6, continued

NET PRESENT VALUE OPERATIONAL PRICE
STATE FISCAL YEARS 2007-2008 – 2011-2012

Net Present Value Discount Rate supplied by Department of Management Services (DMS) = 3.24%

	A	B	C	D
Line #	Month	Total Proposal Price	NPV Factor	Total Net Present Value Price D = (B*C)
31	January 2010	$	0.86683454	$
32	February 2010	$	0.86450039	$
33	March 2010	$	0.86217252	$
34	April 2010	$	0.85985093	$
35	May 2010	$	0.85753558	$
36	June 2010	$	0.85522647	$
37	July 2010	$	0.85292357	$
38	August 2010	$	0.85062688	$
39	September 2010	$	0.84833637	$
40	October 2010	$	0.84605203	$
41	November 2010	$	0.84377384	$
42	December 2010	$	0.84150179	$
43	January 2011	$	0.83923585	$
44	February 2011	$	0.83697602	$
45	March 2011	$	0.83472227	$
46	April 2011	$	0.83247459	$
47	May 2011	$	0.83023296	$
48	June 2011	$	0.82799736	$
49	July 2011	$	0.82576779	$
50	August 2011	$	0.82354422	$
51	September 2011	$	0.82132664	$
52	October 2011	$	0.81911503	$
53	November 2011	$	0.81690937	$
54	December 2011	$	0.81470966	$
55	January 2012	$	0.81251586	$
56	February 2012	$	0.81032798	$
57	March 2012	$	0.80814599	$
58	April 2012	$	0.80596987	$
59	May 2012	$	0.80379961	$
60	June 2012	$	0.80163519	$
61	TOTAL	N/A	N/A	$

Line 61, Column D is the Five (5) Year Total Net Present Value Operational Price. Post this total to Pricing Schedule A, Line 2.

AN AUTHORIZED CORPORATE OFFICIAL OF THE VENDOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE D

PRICE COMPONENTS FOR MITA GAP ANALYSIS JULY 2009 THROUGH DECEMBER 2009.

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE VENDOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE D-1

NET PRESENT VALUE MITA GAP ANALYSIS PRICE

Net Present Value Discount Rate supplied by Department of Management Services (DMS) = 3.24%.

A	B	C	D
Month/Year	Total Proposal Price	NPV Factor	Total Net Present Value Price D = (B * C)
December 2009	$	0.86917499	$

Column D is Total Net Present Value MITA Gap Analysis Price. Post this total to Pricing Schedule A, Line 3.

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PRICING SCHEDULE E

PRICE COMPONENTS FOR ELECTRONIC HEALTH RECORDS (EHR) JULY 2008 THROUGH JUNE 2009

	Price Component	#FTE	Avg. Rate/Hr	Costs
1.	Salaries and Benefits	_____	$_____	$_____
	1a. Management	_____	$_____	$_____
	1b. Supervision	_____	$_____	$_____
	1c. Project Management Staff	_____	$_____	$_____
	1d. QA Staff	_____	$_____	$_____
	1e. Data Administrator	_____	$_____	$_____
	1f. Senior Programmer/Analyst	_____	$_____	$_____
	1g. Programmer/Analyst	_____	$_____	$_____
	1h. Trainer/Publications	_____	$_____	$_____
	1i. Field Representative	_____	$_____	$_____
	1j. Service Representative	_____	$_____	$_____
	1k. Clerical	_____	$_____	$_____
	1l. Medical Professionals	_____	$_____	$_____
	1m. Other Professionals	_____	$_____	$_____
	1n. Total	_____	$_____	$_____
2.	Travel			$_____
3	Building			$_____
4.	Utilities			$_____
5.	Telephone			$_____
6.	Furniture, Office Machines & Other Equipment (include Medicaid Contract Management office furniture)			$_____
7.	Computer Resources			$_____
8.	Consultants	_____	$_____	$_____
9.	Other (Itemize)			$_____
	9a. _____	_____	$_____	$_____
	9b. _____	_____	$_____	$_____
10.	Total (Sum of Lines 1 thorough 9b)	_____		$_____

AN AUTHORIZED CORPORATE OFFICIAL OF THE VENDOR MUST SIGN THIS FORM. THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

PRICING SCHEDULE E-1

NET PRESENT VALUE ELECTRONIC HEALTH RECORD (EHR) PRICE

Net Present Value Discount Rate supplied by Department of Management Services (DMS) = 3.24%.

A	B	C	D	E
Month/Year	Phase Payment	Total Proposal Price	NPV Factor	Total Net Present Value Price E= (C * D)
January 2009	Planning Phase (30%)	$	0.89534082	$
June 2009	Implementation Phase (70%)	$	0.88335102	$
Total		$		$

Column E, Line 3, is Total Net Present Value Operational Price. Post this total to Pricing Schedule A, Line 4.

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70 TECHNICAL PROPOSAL EVALUATION

70.1 Introduction

The State will conduct a comprehensive, fair, and impartial evaluation of proposals received in response to this procurement effort.

This evaluation will be conducted in five (5) phases:

Phase 1 – Evaluation of Mandatory Requirements of Technical Proposals

Phase 2 – Evaluation of Technical Proposals

Phase 3 – Evaluation of Mandatory Requirements of Cost Proposals

Phase 4 – Evaluation of Cost Proposals

Phase 5 – Ranking of Proposals

70.2 Evaluation Procedures

The Technical Proposals will be opened on the date and time listed in Section 20.1 of this RFP. The evaluation process begins with a review of the mandatory items of the Technical Proposals. The technical evaluators will then evaluate the corporate background and experience, project management, technical approach, including the project organization and staffing for each phase of the contract, and data processing sections of all responsive Technical Proposals.

The Cost Proposals will be opened on the date and time listed in Section 20.1 of this RFP and evaluated upon completion of the Technical Proposal evaluation. The Cost Proposal evaluation process begins with a review of the mandatory items of the Cost Proposals. The Cost Proposal evaluators will evaluate the price for each component and the total proposal price for each Cost Proposal.

The Issuing Officer will rank Vendors by the resulting scores and summarize the findings in a report presented to the Contracting Officer.

70.3 Evaluation Organization

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

70.4 Phase 1 - Evaluation of Mandatory Requirements of Technical Proposal

Each proposal will be reviewed for responsiveness to the mandatory requirements set forth in this RFP. This will be a yes/no evaluation. The purpose of this phase is to determine if the Technical Proposal is sufficiently responsive to the RFP to permit a complete evaluation.

Mandatory requirements for the Technical Proposal are presented in a checklist in Appendix M.

Failure to comply with the instructions or to submit a complete proposal will deem a proposal non-responsive, and will cause the proposal to be rejected with no further evaluation. The State reserves the right to waive minor irregularities.

No points will be awarded for passing the mandatory requirements.

70.5 Phase 2 - Evaluation of Technical Proposals

Only those proposals passing the mandatory requirements will be considered in Phase 2.

The written proposals will be evaluated during this phase and comprise the substantive portion of the technical evaluation. The State will evaluate the responses based on the instructions provided in this RFP, including the instruction to Vendor regarding the detail of their responses. In Section 60, Vendors have been instructed to not simply provide statements that the requirements of the RFP will be met, but to respond concisely but fully with their approach and how they will comply with the requirements in each item listed in "Contractor's Responsibilities" in Section 40, (including any Contractor responsibilities found in Section 40.1) of this RFP and to any Contractor requirements in Sections 30 and 50 of this RFP. Additionally, Vendors must acknowledge their understanding of each Overview, Inputs, Outputs, and State Responsibility section in Section 40 of this RFP. The criteria used to evaluate the Technical Proposals are described in the subsections below. Any Technical Proposal in which there are significant inconsistencies or inaccuracies may be rejected by the State. The State reserves the right to reject any and all proposals.

As a part of the Phase 2 evaluation, the State will require oral presentations by Vendors successfully completing mandatory requirements. The oral presentations will be arranged with Vendors individually during the State's evaluation phase. The State shall expect proposed project managers to play a key role in oral presentations. The State will make site visits during the evaluation phase to Vendor locations at which MMIS/DSS or large medical claim payment systems are operational or at which the Vendor provides fiscal agent services. The State will select the location of the site visit from a list of suggested sites supplied by the Vendor. It shall be the State's preference to visit sites at which an operational MMIS/DSS system has been developed and installed by the Vendor at a site that is comparable in size and complexity to the Florida Medicaid program. At the site visits, each Vendor shall be expected to respond to specific questions and to have appropriate personnel (including the proposed project manager) available for discussions. Relevant systems documentation, procedure manuals, edit tables, and operational processes shall be available for review by State staff. The State staff that conducts the site visits will record their observations of the Vendor's operations at the site selected, which will be shared with all evaluators.

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

70.5.1 Technical Proposal Points (1,400 points)

The evaluation of Technical Proposals will involve the point scoring of each proposal according to pre-established criteria. A maximum of one thousand four-hundred (1,400) points will be available for each Vendor's Technical Proposal. The areas are in which technical proposals will be evaluated are:

Corporate Background and Experience	200
Project Management	150
Technical Approach to Design and Development	150
Technical Approach to Implementation Planning	100
Technical Approach to Implementation	100
Technical Approach to Operations	250
Technical Approach to MMIS Certification	100
Technical Approach to Electronic Health Records	75
Technical Approach to MITA Gap Analysis	75
Technical Approach to Turnover	50
Data Processing	150

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

70.5.2 Corporate Background and Experience (200 points)

The evaluators will evaluate the experience, performance, corporate resources, and corporate qualifications of the Vendor and any subcontractors. References will be verified and findings will be incorporated into the evaluation of the corporation. Reference checking may not be limited to those references supplied by the Vendor. The evaluation criteria for corporate background and experience are:

1. Large-scale data processing system development;
2. MMIS/DSS or similar health care claims processing experience (system planning, design, development, implementation and operation);
3. Experience with Web-based approaches to claims processing;
4. Experience with multiple benefit plan administration;
5. Experience working with managed care providers and processing encounter claims;
6. Fiscal agent or fiscal intermediary experience;
7. Experience with other health care systems;
8. Corporate financial statements;
9. Personnel resources; and
10. Computer resources.

70.5.3 Project Management (150 points)

This part of the evaluation assesses the Vendor's overall approach to project management and project control in terms of the Vendor's previous ability to use those tools to successfully complete projects on schedule, as well as the specific project management approach in each phase. Project Management activities that are specific to a phase of the project will be part of the evaluation of the individual phases. The evaluation criteria for overall project management are:

1. Project management approach;
2. Authority of project manager;
3. Project control approach (including previous ability to use control tools to successfully complete projects on schedule; plan for reporting to the State);
4. Work hours and time estimating methods;
5. Sign-off procedures and internal control over deliverable production and major activities;
6. Assessment of project risks and anticipated problem areas, and the Vendor's approach to managing them;
7. Approach to routine problem identification, prevention, and interfaces with the State, including resolution;
8. Approach to interfaces with the State;
9. Practicality and effectiveness of the Vendor's quality assurance plan for this contract;
10. Assessment of Vendor's assumptions and constraints;
11. Assessment of Vendor's approach to the Contract Phases described in Section 50.1;
12. Assessment of the Vendor's approach to the requirements in Section 30 (see the list to be considered in Section 60.2.5; and
13. Approach to use of walk-throughs with users to ensure agreement and understanding of each task.

70.5.4 Project Staffing

The evaluation of project staffing will be conducted during the evaluation of each phase of this RFP and will include detailed criteria evaluating the Vendor's staffing approach, the qualifications of named personnel, and the past performance of the company and the individuals for each phase of the contract. No separate points are awarded for project staffing alone. The proposed project organization and use of staff resources will also be evaluated to assess the Vendor's capability to perform all major tasks within the project timetable for each phase. References for proposed individuals will be checked and included in the evaluation of each technical phase section. Reference checking is not limited to those references supplied by the Vendor. Requirements for organization, staffing, and the personal experience of specified management positions are defined in Section 50 of this RFP. The evaluation criteria that will be applied to the Vendor's approach to staffing for each phase are:

1. Organization structure and staffing levels for all project phases;
2. Relative experience of management and key professional personnel for whom resumes are supplied; and
3. Number of full-time equivalent personnel by staff level proposed for each task.

The evaluation criteria for the Vendor's management personnel for whom resumes are required are:

1. Experience with Vendor (or subcontractor);

2. Experience with Medicaid or other large scale health care claims processing systems;
3. Large scale data processing systems design, development, implementation and operations;
4. Experience with the focus of the phase to which the personnel are assigned;
5. Project management experience;
6. Other data processing experience;
7. Education; and
8. References.

70.5.5 Technical Approach to Design and Development (150 points)

Evaluation criteria for this section assess the Vendor's approach to the design and development phase. The evaluation criteria for technical approach to design and development are:

1. Approach to Planning:
   a. Assumptions and constraints associated with the work plan;
   b. Person loading of work plan tasks, including separately identified Contractor and State staff;
   c. Adequacy of the work plan;
   d. Logical structure of work plan and supporting Gantt chart and critical path diagram;
   e. Provision for handling problem identification and resolution; and
   f. Schedule (including adequate review time by the State) for each deliverable;
2. Approach to Project Management:
   a. Project management approach to this phase;
   b. Authority of project manager for this phase;
   c. Project control approach (including reporting to the State);
   d. Work hours and time estimating methods;
   e. Sign-off procedures and internal quality control for completion of all deliverables and major activities;
   f. Assessment of project risks and anticipated problem areas, and the Vendor's approach to managing them;
   g. Approach to routine problem identification and resolution;
   h. Approach to interfaces with the State;
   i. Approach to Quality Control;
   j. Assumptions and constraints associated with this phase; and
   k. Use of walk-throughs for each major task.
3. Approach to Requirements Analysis;

4. Approach to Business and Technical Design;
5. Approach to the use of COTS;
6. Approach to use of subcontractors to address specialized areas of the requirements;
7. Approach to the use of Web-based applications;
8. Approach to the use of relational database applications;
9. Approach to use of rules engine for:
    a. Benefit plan administration;
    b. Provider enrollment processing;
    c. Claims and encounter adjudication;
    d. System monitoring; and
    e. Report production;
10. Approach to Comprehensive Testing Plan;
11. Approach to Risk Analysis and Contingency Planning;
12. Approach to Technical Design and Development;
13. Approach to Testing Execution;
14. Adequacy of Deliverable Prototypes; and
15. Approach to Staffing for Design and Development Phase (see Section 70.4.4 Project Staffing).

70.5.6 Technical Approach to Implementation Planning (100 points)

Evaluation criteria for this section assess the Vendor's approach to the implementation planning. The evaluation criteria for technical approach to implementation planning are:

1. Approach to Planning:
    a. Assumptions and constraints associated with the work plan;
    b. Person loading of work plan tasks, including separately identified Contractor and State staff;
    c. Adequacy of the work plan;
    d. Logical structure of work plan and supporting Gantt chart and critical path diagram;
    e. Provision for handling problem identification and resolution; and
    f. Schedule (including adequate review time by the State) for each deliverable;
2. Approach to Project Management:
    a. Project management approach to this phase;
    b. Authority of project manager for this phase;
    c. Project control approach (including reporting to the State);
    d. Work hours and time estimating methods;

e. Sign-off procedures and internal quality control for completion of all deliverables and major activities;

f. Assessment of project risks and anticipated problem areas, and the Vendor's approach to managing them;

g. Approach to routine problem identification and resolution;

h. Approach to interfaces with the State;

i. Approach to Quality Control;

j. Assumptions and constraints associated with this phase; and

k. Use of walk-throughs for each major task.

3. Approach to Requirements Analysis;
4. Approach to Cooperation with Incumbent;
5. Approach to Data Conversion;
6. Approach to Comprehensive Testing Plan;
7. Approach to Risk Analysis and Contingency Planning;
8. Approach to Testing Execution;
9. Adequacy of Deliverable Prototypes; and
10. Approach to Staffing for Implementation Planning Phase (see Section 70.4.4 Project Staffing).

70.5.7 Technical Approach to Implementation (100 points)

Evaluation criteria for this section assess the Vendor's approach to the implementation phase. The evaluation criteria for technical approach to implementation are:

1. Approach to Planning:
   a. Assumptions and constraints associated with the work plan;

   b. Person loading of work plan tasks, including separately identified Contractor and State staff;

   c. Adequacy of the work plan;

   d. Logical structure of work plan and supporting Gantt chart and critical path diagram;

   e. Provision for handling problem identification and resolution; and

   f. Schedule (including adequate review time by the State) for each deliverable;

2. Approach to Project Management:

   a. Project management approach to this phase;

   b. Authority of project manager for this phase;

   c. Project control approach (including reporting to the State);

   d. Work hours and time estimating methods;

e. Sign-off procedures and internal quality control for completion of all deliverables and major activities;

f. Assessment of project risks and anticipated problem areas, and the Vendor's approach to managing them;

g. Approach to routine problem identification and resolution;

h. Approach to interfaces with the State;

i. Approach to Quality Control;

j. Assumptions and constraints associated with this phase; and

k. Use of walk-throughs for each major task.

3. Approach to Implementation Activities;
4. Approach to Correction and Adjustment Activities;
5. Approach to Execution of Contingency Plans;
6. Approach to Finalized Implementation Schedule;
7. Approach to Implementation of all Components;
8. Adequacy of Deliverable Prototypes; and
9. Staffing for the Implementation Phase, including the transition of staffing from the Design and Development and Implementation Planning Phases into the Operations Phase. (see Section 70.4.4 Project Staffing).

70.5.8 Technical Approach to Operations (250 points)

Evaluation criteria for this section assess the Vendor’s approach to the ongoing operations. The evaluation criteria for ongoing operations are:

1. Approach to Project Management:
   a. Project management approach to this phase;
   b. Authority of project manager for this phase;
   c. Project control approach (including reporting to the State);
   d. Work hours and time estimating methods;
   e. Sign-off procedures and internal quality control for completion of all deliverables and major activities;
   f. Assessment of project risks and anticipated problem areas, and the Vendor's approach to managing them;
   g. Approach to routine problem identification and resolution;
   h. Approach to interfaces with the State;
   i. Approach to Quality Control;
   j. Assumptions and constraints associated with this phase; and
   k. Use of walk-throughs for each major task.

2. Approach to Operations Requirements in Section 40.1:
   a. General Requirements;
   b. MITA Concept;
   c. General System and Business Requirements;
   d. Data Processing Standards;
   e. Deliverables Standards;
   f. Standards for MITA Architecture Components; and
   g. Business Processes;
3. Acknowledgement of all information contained in the Overview, State Objectives, Interfaces, Inputs, Outputs and State Responsibilities sections of 40.2 through 40.5;
4. Detailed Approach to Contractor Responsibilities in Section 40.2 through 40.5:
   a. Eligibility Determination;
   b. Benefit Plan Administration;
   c. Recipient Enrollment;
   d. Buy-In;
   e. CHCUP;
   f. Eligibility Verification;
   g. Recipient Communications;
   h. Recipient Maintenance;
   i. Provider Enrollment Administration;
   j. Provider Enrollment Processing;
   k. Provider Communications;
   l. Provider Maintenance;
   m. Service Authorization;
   n. COB;
   o. Claims Processing Administration;
   p. Adjudication of Claims and Encounters;
   q. Provider Payments;
   r. Adjustments and Voids;
   s. Provider Communications Regarding Payments;
   t. Data Administration;
   u. Management Reporting;
   v. Health Outcome Measurement; and
   w. Fraud and Abuse Detection;
5. Adequacy of Appendix O;

6. Approach to Facilities Requirements:
    a. Communications Requirements;
    b. Meeting Room Requirements;
    c. Location of Operations Facilities;
    d. Space for File and Archive Storage;
    e. State Access to Processing Facilities and Contractor Staff;
    f. Computer Resources;
    g. Location of Backup and Contingency Facilities;
    h. Location of System Analysis and Programming Resources; and
    i. Location of Subcontractors;
7. Approach to Staffing for Operations Phase (see Section 70.4.4 Project Staffing).

70.5.9 Technical Approach to MMIS Certification (100 points)

Evaluation criteria for this section assess the Vendor's approach to the MMIS Certification phase. The evaluation criteria for technical approach to MMIS certification are:

1. Approach to Planning:
    a. Assumptions and constraints associated with the work plan;
    b. Person loading of work plan tasks, including separately identified Contractor and State staff;
    c. Adequacy of the work plan;
    d. Logical structure of work plan and supporting Gantt chart and critical path diagram;
    e. Provision for handling problem identification and resolution; and
    f. Schedule (including adequate review time by the State) for each deliverable;
2. Approach to Project Management
    a. Project management approach to this phase;
    b. Authority of project manager for this phase;
    c. Project control approach (including reporting to the State);
    d. Work hours and time estimating methods;
    e. Sign-off procedures and internal quality control for completion of all deliverables and major activities;
    f. Assessment of project risks and anticipated problem areas, and the Vendor's approach to managing them;
    g. Approach to routine problem identification and resolution;
    h. Approach to interfaces with the State;
    i. Approach to Quality Control;

j. Assumptions and constraints associated with this phase; and

k. Use of walk-throughs for each major task.

3. Approach to Meet with Federal and State Certification Team;
4. Approach to System Remediation, if needed to obtain certification;
5. Adequacy of Deliverable Prototypes; and
6. Approach to Staffing for MMIS Certification (see 70.4.4).

70.5.10 Technical Approach to Electronic Health Records (75 points)

Evaluation criteria for this section assess the Vendor's approach to the Electronic Health Records phase. The evaluation criteria for technical approach to electronic health records are:

1. Approach to Planning:
   a. Assumptions and constraints associated with the work plan;
   b. Person loading of work plan tasks, including separately identified Contractor and State staff;
   c. Adequacy of the work plan;
   d. Logical structure of work plan and supporting Gantt chart and critical path diagram;
   e. Provision for handling problem identification and resolution; and
   f. Schedule (including adequate review time by the State) for each deliverable;
2. Approach to Project Management
   a. Project management approach to this phase;
   b. Authority of project manager for this phase;
   c. Project control approach (including reporting to the State);
   d. Work hours and time estimating methods;
   e. Sign-off procedures and internal quality control for completion of all deliverables and major activities;
   f. Assessment of project risks and anticipated problem areas, and the Vendor's approach to managing them;
   g. Approach to routine problem identification and resolution;
   h. Approach to interfaces with the State;
   i. Approach to Quality Control;
   j. Assumptions and constraints associated with this phase; and
   k. Use of walk-throughs for each major task.
3. Approach to General Planning with the State;
4. Approach to Research of Alternative Record Formats for EHR;
5. Approach to Research of Alternative Methods to Collect the Required Data;

6. Approach to Development of HIPAA Privacy and Security Requirements;
7. Approach to Provider/Recipient/Others Outreach Efforts, including how EHRs may be accessed;
8. Adequacy of EHR Deliverable Prototypes; and
9. Approach to Staffing for EHR (see Section 70.4.4 Project Staffing).

70.5.11 Technical Approach to MITA Gap Analysis (75 points)

Evaluation criteria for this section assess the Vendor's approach to the Medicaid Information Technology Architecture (MITA) Gap Analysis. The evaluation criteria for this area are:

1. Approach to Planning:
   a. Assumptions and constraints associated with the work plan;
   b. Person loading of work plan tasks, including separately identified Contractor and State staff;
   c. Adequacy of the work plan;
   d. Logical structure of work plan and supporting Gantt chart and critical path diagram;
   e. Provision for handling problem identification and resolution; and
   f. Schedule (including adequate review time by the State) for each deliverable;
2. Approach to Project Management
   a. Project management approach to this phase;
   b. Authority of project manager for this phase;
   c. Project control approach (including reporting to the State);
   d. Work hours and time estimating methods;
   e. Sign-off procedures and internal quality control for completion of all deliverables and major activities;
   f. Assessment of project risks and anticipated problem areas, and the Vendor's approach to managing them;
   g. Approach to routine problem identification and resolution;
   h. Approach to interfaces with the State;
   i. Approach to Quality Control;
   j. Assumptions and constraints associated with this phase; and
   k. Use of walk-throughs for each major task.
3. Approach to General Planning with State;
4. Approach to determining current MITA development and incorporating that into the MITA Gap Analysis report and any revisions as required by the State;
5. Adequacy of MITA Deliverable Prototypes; and

6. Approach to Staffing Requirements for MITA Gap Analysis (see Section 70.4.4 Project Staffing).

70.5.12 Technical Approach to Turnover (50 points)

Evaluation criteria for this section assess the Vendor's approach to the turnover phase. The evaluation criteria for technical approach to turnover are:

1. Approach to Planning:
    a. Assumptions and constraints associated with the work plan;
    b. Person loading of work plan tasks, including separately identified Contractor and State staff;
    c. Adequacy of the work plan;
    d. Logical structure of work plan and supporting Gantt chart and critical path diagram;
    e. Provision for handling problem identification and resolution; and
    f. Schedule (including adequate review time by the State) for each deliverable;
2. Approach to Project Management
    a. Project management approach to this phase;
    b. Authority of project manager for this phase;
    c. Project control approach (including reporting to the State);
    d. Work hours and time estimating methods;
    e. Sign-off procedures and internal quality control for completion of all deliverables and major activities;
    f. Assessment of project risks and anticipated problem areas, and the Vendor's approach to managing them;
    g. Approach to routine problem identification and resolution;
    h. Approach to interfaces with the State;
    i. Approach to Quality Control;
    j. Assumptions and constraints associated with this phase; and
    k. Use of walk-throughs for each major task.
3. Approach to General Planning with State;
4. Approach to General Planning with Successor;
5. Approach to Providing Turnover Services;
6. Approach to Providing Contract Closeout Services;
7. Approach to Contractor Responsibilities;
8. Approach to Deliverables; and
9. Approach to Staffing for Turnover (see Section 70.4.4 Project Staffing).

70.5.13 Data Processing (150 points)

This area includes assessment of the Vendor's technical data processing approach, the extent to which the data processing standards are met (as referenced in Section 40), and the operational computer requirements of FMMIS. Evaluators will evaluate the extent to which the Vendor's proposed equipment support and processing methodology indicate that the RFP performance standards will be met, including consideration of the Vendor's previous success with similar performance requirements. Reference checks may be used to assess Vendor's performance in this area. The evaluation criteria for data processing are:

1. Description and location of data and fiscal agent operations facility in Tallahassee:
    a. List of local hardware/software, and
    b. List of corporate site hardware/software;
2. Location of:
    a. Computer resources;
    b. Back-up and contingency facilities;
    c. System analyst and programmers resources; and
    d. Subcontractors;
3. Approach to system capacity evaluation and planning;
4. Approach to data processing standards;
5. Approach to the use of COTS and Web-based solutions;
6. Approach to imaging and data entry;
7. Approach to telecommunication network description;
8. Approach to security and confidentiality;
9. Approach to documentation; and
10. Approach to procurement of State hardware.

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70.5.14 Technical Proposal Scoring

Scoring of Technical Proposals shall be done using pre-established criteria and predefined scoring values. Evaluators will independently score each criterion within an area. Individual raw scores from the evaluators, for each criterion for each Vendor's proposal, will be averaged. Values for all criteria in a Vendor's proposal will then be totaled. The final technical score for each proposal will then be calculated using the following methodology:

A maximum of one thousand four hundred (1,400) points will be assigned to the highest passing Technical Proposal.

Points for other proposals will be assigned using the formula:

(N/X) x 1,400 = Z

Where:

X = highest points awarded to a proposal

N = actual points awarded to the Vendor's proposal

Z = final technical score for Vendor

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80 COST PROPOSAL EVALUATION

80.1 Phase 3 - Evaluation of Mandatory Requirements of Cost Proposal

Upon completion of the evaluation of all Technical Proposals, Cost Proposals will be opened on the date specified in the RFP Timetable, Section 20.1. The Cost Proposals will be evaluated to ensure that all mandatory requirements have been met. The purpose of this phase is to determine if the Cost Proposal is sufficiently responsive to the RFP requirements as stated in Section 60 and the Cost Proposal required items included in Appendix M to permit a complete evaluation.

No points will be awarded for passing mandatory requirements.

80.2 Phase 4 - Evaluation of Cost Proposals

Each Cost Proposal successfully meeting the mandatory requirements reviewed in Phase 3 will be examined to determine if the Cost Proposal is consistent with the Technical Proposal and its calculations are accurate. All Cost Proposals shall be evaluated using net present value methodology in accordance with Chapter 287 of the Florida Statutes, Section 287.0572. All pricing schedules will be examined for consistency and accuracy.

A total of 600 points will be awarded to the lowest acceptable price from Pricing Schedule A, Line 5.

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

$(X/N) \times 600 = Z$

Where:

X = lowest price proposal

N = proposal price

Z = awarded points

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90 RANKING OF PROPOSALS

90.1 Introduction

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

90.2 Federal Approval

Federal approval of the contract for services between the selected Vendor and the Agency is required from the Centers for Medicare and Medicaid Services (CMS). Every effort will be made by the State to obtain and expedite federal approval.

90.3 Posting of Notice of Intent to Award

The Contracting Officer shall review the work of the evaluators and approve the determination for contract award. A Notice of Intent to Award shall be posted at the anticipated date and time specified in Section 20.1 of this RFP, on the DMS Vendor Web site at http://fcn.state.fl.us/owa_vbs/owa/vbs_www.search.criteria_form. The notice shall remain posted for a period of seventy-two (72) hours. Upon the decision to award the contract, all Vendors who submitted proposals will also be notified by email of the intent to award the contract.

90.4 Contract Award

Immediately after obtaining all federal and state approvals, the Agency will forward the contract to the selected Vendor. If no signed contract is received from the selected Vendor within ten (10) workdays of the selected Vendor's receipt of the contract form, the proposal bond may be forfeited and the Agency will make another selection. These procedures will be repeated as necessary. If all proposals are rejected, Vendors will be promptly notified on the DMS Vendor Web site.

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ATTACHMENT A

Contract No._____

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
STANDARD CONTRACT

THIS CONTRACT is entered into between the State of Florida, **AGENCY FOR HEALTH CARE ADMINISTRATION**, hereinafter referred to as the "**Agency**", whose address is 2727 Mahan Drive, Tallahassee, Florida 32308, and , hereinafter referred to as the "**Vendor**", whose address is , , , , a Enter organization type - Go to www.sunbiz.org, to provide .

I. THE VENDOR HEREBY AGREES:

A. General Provisions

1. To provide services according to the terms and conditions set forth in this Contract, Attachment I, Scope of Services, and all other attachments named herein which are attached hereto and incorporated by reference.

2. To perform as an independent vendor and not as an agent, representative, or employee of the Agency.

3. To recognize that the State of Florida, by virtue of its sovereignty, is not required to pay any taxes on the services or goods purchased under the terms of this Contract.

B. Federal Laws and Regulations

1. If this Contract contains federal funds, the Vendor shall comply with the provisions of 45 CFR, Part 74, and/or 45 CFR, Part 92, and other applicable regulations as specified in **Attachment** .

2. If this Contract contains federal funding in excess of $100,000, the Vendor must, upon Contract execution, complete the Certification Regarding Lobbying form, **Attachment** . If a Disclosure of Lobbying Activities form, Standard Form LLL, is required, it may be obtained from the Agency's Contract Manager. All disclosure forms as required by the Certification Regarding Lobbying form must be completed and returned to the Agency's Contract Manager.

3. Pursuant to 45 CFR, Part 76, if this Contract contains federal funding in excess of $25,000, the Vendor must, upon Contract execution, complete the Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion Contracts/Subcontracts, **Attachment** .

C. Audits and Records

1. To maintain books, records, and documents (including electronic storage media) pertinent to performance under this Contract in accordance with generally accepted accounting procedures and practices which sufficiently and properly

reflect all revenues and expenditures of funds provided by the Agency under this Contract.

2. To assure that these records shall be subject at all reasonable times to inspection, review, or audit by state personnel and other personnel duly authorized by the Agency, as well as by federal personnel.

3. To maintain and file with the Agency such progress, fiscal and inventory reports as specified in **Attachment** , and other reports as the Agency may require within the period of this Contract.

4. To provide a financial and compliance audit to the Agency as specified in **Attachment II** and to ensure that all related party transactions are disclosed to the auditor. Additional audit requirements are specified in **Attachment I**, Special Provisions, Section .

5. To include these aforementioned audit and record keeping requirements in all approved subcontracts and assignments.

D. Retention of Records

1. To retain all financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to performance under this Contract for a period of five (5) years after termination of this Contract, or if an audit has been initiated and audit findings have not been resolved at the end of five (5) years, the records shall be retained until resolution of the audit findings.

2. Persons duly authorized by the Agency and federal auditors, pursuant to 45 CFR, Part 74 and/or 45 CFR, Part 92, shall have full access to and the right to examine any of said records and documents.

3. The rights of access in this section must not be limited to the required retention period but shall last as long as the records are retained.

E. Monitoring

1. To provide reports as specified in **Attachment** . These reports will be used for monitoring progress or performance of the contractual services as specified in **Attachment** .

2. To permit persons duly authorized by the Agency to inspect any records, papers, documents, facilities, goods and services of the Vendor which are relevant to this Contract.

F. Indemnification

The Contractor shall save and hold harmless and indemnify the State of Florida and the Agency against any and all liability, claims, suits, judgments, damages or costs of whatsoever kind and nature resulting from the use, service, operation or performance of work under the terms of this Contract, resulting from any act, or failure to act, by the Vendor, his sub-vendor, or any of the employees, agents or representatives of the Vendor or sub-vendor.

G. Insurance

1. To the extent required by law, the Vendor will be self-insured against, or will secure and maintain during the life of the Contract, Worker's Compensation Insurance for all his employees connected with the work of this project and, in case any work is subcontracted, the Vendor shall require the sub-vendor similarly to provide Worker's Compensation Insurance for all of the latter's employees unless such employees engaged in work under this Contract are covered by the Vendor's self insurance program. Such self insurance or insurance coverage shall comply with the Florida Worker's Compensation law. In the event hazardous work is being performed by the Vendor under this Contract and any class of employees performing the hazardous work is not protected under Worker's Compensation statutes, the Vendor shall provide, and cause each sub-vendor to provide, adequate insurance satisfactory to the Agency, for the protection of his employees not otherwise protected.

2. The Vendor shall secure and maintain Commercial General Liability insurance including bodily injury, property damage, personal & advertising injury and products and completed operations. This insurance will provide coverage for all claims that may arise from the services and/or operations completed under this Contract, whether such services and/or operations are by the Vendor or anyone directly, or indirectly employed by him. Such insurance shall include a Hold Harmless Agreement in favor of the State of Florida and also include the State of Florida as an Additional Named Insured for the entire length of the Contract. The Vendor is responsible for determining the minimum limits of liability necessary to provide reasonable financial protections to the Vendor and the State of Florida under this Contract.

3. All insurance policies shall be with insurers licensed or eligible to transact business in the State of Florida. The Vendor's current certificate of insurance shall contain a provision that the insurance will not be canceled for any reason except after thirty (30) days written notice to the Agency's Contract Manager.

H. Assignments and Subcontracts

To neither assign the responsibility of this Contract to another party nor subcontract for any of the work contemplated under this Contract without prior written approval of the Agency. No such approval by the Agency of any assignment or subcontract shall be deemed in any event or in any manner to provide for the incurrence of any obligation of the Agency in addition to the total dollar amount agreed upon in this Contract. All such assignments or subcontracts shall be subject to the conditions of this Contract and to any conditions of approval that the Agency shall deem necessary.

I. Financial Reports

To provide financial reports to the Agency as specified in **Attachment** .

J. Return of Funds

To return to the Agency any overpayments due to unearned funds or funds disallowed pursuant to the terms of this Contract that were disbursed to the Vendor by the Agency. The Vendor shall return any overpayment to the Agency within forty

(40) calendar days after either discovery by the Vendor, its independent auditor, or notification by the Agency, of the overpayment.

K. Purchasing

1. P.R.I.D.E.

It is expressly understood and agreed that any articles which are the subject of, or required to carry out this Contract shall be purchased from the corporation identified under Chapter 946, Florida Statutes, if available, in the same manner and under the same procedures set forth in Section 946.515(2), (4), Florida Statutes; and for purposes of this Contract the person, firm or other business entity carrying out the provisions of this Contract shall be deemed to be substituted for this agency insofar as dealings with such corporation are concerned.

The “Corporation identified” is PRISON REHABILITATIVE INDUSTRIES AND DIVERSIFIED ENTERPRISES, INC. (P.R.I.D.E.) which may be contacted at:

P.R.I.D.E.
2720-G Blair Stone Road
Tallahassee, Florida 32301
(850) 487-3774
Toll Free: 1-800-643-8459
Website: www.pridefl.com

2. RESPECT of Florida

It is expressly understood and agreed that any articles that are the subject of, or required to carry out, this Contract shall be purchased from a nonprofit agency for the blind or for the severely handicapped that is qualified pursuant to Chapter 413, Florida Statutes, in the same manner and under the same procedures set forth in Section 413.036(1) and (2), Florida Statutes; and for purposes of this Contract the person, firm, or other business entity carrying out the provisions of this Contract shall be deemed to be substituted for the state agency insofar as dealings with such qualified nonprofit agency are concerned.

The "nonprofit agency” identified is RESPECT of Florida which may be contacted at:

RESPECT of Florida.
2475 Apalachee Parkway, Suite 205
Tallahassee, Florida 32301-4946
(850) 487-1471
Website: www.respectofflorida.org

3. Procurement of Products or Materials with Recycled Content

It is expressly understood and agreed that any products which are required to carry out this Contract shall be procured in accordance with the provisions of Section 403.7065, Florida Statutes.

L. Civil Rights Requirements/Vendor Assurance

The Vendor assures that it will comply with:

1. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin.
2. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap.
3. Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex.
4. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age.
5. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs.
6. The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities.
7. All regulations, guidelines, and standards as are now or may be lawfully adopted under the above statutes.

The Vendor agrees that compliance with this assurance constitutes a condition of continued receipt of or benefit from funds provided through this Contract, and that it is binding upon the Vendor, its successors, transferees, and assignees for the period during which services are provided. The Vendor further assures that all Vendors, sub-vendors, subgrantees, or others with whom it arranges to provide services or benefits to participants or employees in connection with any of its programs and activities are not discriminating against those participants or employees in violation of the above statutes, regulations, guidelines, and standards.

M. Discrimination

An entity or affiliate who has been placed on the discriminatory vendor list may not submit a bid, proposal, or reply on a contract to provide any goods or services to a public entity; may not submit a bid, proposal, or reply on a contract with a public entity for the construction or repair of a public building or public work; may not submit bids, proposals, or replies on leases of real property to a public entity; may not be awarded or perform work as a Vendor, supplier, sub-vendor, or consultant under a contract with any public entity; and may not transact business with any public entity. The Florida Department of Management Services is responsible for maintaining the discriminatory vendor list and intends to post the list on its website. Questions regarding the discriminatory vendor list may be directed to the Florida Department of Management Services, Office of Supplier Diversity at (850) 487-0915.

N. Requirements of Section 287.058, Florida Statutes

1. To submit bills for fees or other compensation for services or expenses in sufficient detail for a proper pre-audit and post-audit thereof.

2. Where applicable, to submit bills for any travel expenses in accordance with Section 112.061, Florida Statutes. The Agency may, when specified in **Attachment** , establish rates lower than the maximum provided in Section 112.061, Florida Statutes.

3. To provide units of deliverables, including reports, findings, and drafts as specified in **Attachment** , to be received and accepted by the Contract Manager prior to payment.

4. To comply with the criteria and final date by which such criteria must be met for completion of this Contract as specified in Section III, Paragraph A. of this Contract.

5. To allow public access to all documents, papers, letters, or other material made or received by the Vendor in conjunction with this Contract, unless the records are exempt from Section 24(a) of Article I of the State Constitution and Section 119.07(1), Florida Statutes. It is expressly understood that substantial evidence of the Vendor's refusal to comply with this provision shall constitute a breach of Contract.

6. In accordance with Section 287.057 (14), this Contract may be renewed for a period that may not exceed three (3) years or the term of the original Contract, whichever period is longer, unless otherwise specified in **Attachment I**. Renewal of this Contract shall be in writing and subject to the same terms and conditions set forth in the initial Contract prior to Contract termination. A renewal contract may not include any compensation for costs associated with the renewal. Renewals are contingent upon satisfactory performance evaluations by the Agency and subject to the availability of funds. A renewal clause, including terms under which the cost may change, must be specified in the invitation to bid, request for proposal, or other bid instrument, if applicable. This Contract may not be renewed if it is the result of an emergency or single source method of procurement.

O. Sponsorship

As required by Section 286.25, Florida Statutes, if the Vendor is a nongovernmental organization which sponsors a program financed wholly or in part by state funds, including any funds obtained through this Contract, it shall, in publicizing, advertising or describing the sponsorship of the program, state:

"Sponsored by **ENTER VENDOR NAME OR N/A IF A GOVERNMENTAL ORGANIZATION** and the State of Florida, AGENCY FOR HEALTH CARE ADMINISTRATION".

If the sponsorship reference is in written material, the words "State of Florida, AGENCY FOR HEALTH CARE ADMINISTRATION" shall appear in the same size letters or type as the name of the organization.

P. Final Invoice

The Vendor must submit the final invoice for payment to the Agency no more than days after the Contract ends or is terminated. If the Vendor fails to do so, all right to payment is forfeited and the Agency will not honor any requests submitted after the aforesaid time period. Any payment due under the terms of this Contract may be withheld until all reports due from the Vendor and necessary adjustments thereto have been approved by the Agency.

Q. Use Of Funds For Lobbying Prohibited

To comply with the provisions of Section 216.347, Florida Statutes, which prohibits the expenditure of Contract funds for the purpose of lobbying the Legislature, the judicial branch or a state agency.

R. Public Entity Crime

A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not be awarded or perform work as a Vendor, supplier, sub-vendor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in Section 287.017, Florida Statutes, for category two, for a period of 36 months from the date of being placed on the convicted vendor list.

S. Health Insurance Portability and Accountability Act

To comply with the Department of Health and Human Services Privacy Regulations in the Code of Federal Regulations, Title 45, Sections 160 and 164, regarding disclosure of protected health information as specified in **Attachment III**.

T. Confidentiality of Information

Not to use or disclose any confidential information, including social security numbers that may be supplied under this Contract pursuant to law, and also including the identity or identifying information concerning a Medicaid recipient or services under this Contract for any purpose not in conformity with state and federal laws, except upon written consent of the recipient, or his/her guardian.

U. Employment

To comply with Section 274A (e) of the Immigration and Nationality Act. The Agency shall consider the employment by any Vendor of unauthorized aliens a violation of this Act. If the Vendor knowingly employs unauthorized aliens, such violation shall be cause for unilateral cancellation of this Contract. The Vendor shall be responsible for including this provision in all subcontracts with private organizations issued as a result of this Contract.

II. THE AGENCY HEREBY AGREES:

A. Contract Amount

To pay for contracted services according to the conditions of **Attachment I** in an amount not to exceed **$** , subject to the availability of funds. The State of Florida's performance and obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature.

B. Contract Payment

Section 215.422, Florida Statutes, provides that agencies have 5 working days to inspect and approve goods and services, unless bid specifications, Contract or purchase order specifies otherwise. With the exception of payments to health care providers for hospital, medical, or other health care services, if payment is not

available within forty (40) days, measured from the latter of the date the invoice is received or the goods or services are received, inspected and approved, a separate interest penalty set by the Comptroller pursuant to Section 55.03, F. S., will be due and payable in addition to the invoice amount. To obtain the applicable interest rate, please contact the Agency's Fiscal Section at (850) 488-5869. Payments to health care providers for hospitals, medical or other health care services, shall be made not more than 35 days from the date of eligibility for payment is determined, and the daily interest rate is .0003333%. Invoices returned to a vendor due to preparation errors will result in a payment delay. Invoice payment requirements do not start until a properly completed invoice is provided to the Agency. A Vendor Ombudsman, whose duties include acting as an advocate for vendors who may be experiencing problems in obtaining timely payment(s) from a State agency, may be contacted at (850) 410-9724 or by calling the State Comptroller's Hotline, 1-800-848-3792.

III. THE VENDOR AND AGENCY HEREBY MUTUALLY AGREE:

A. Effective/End Date

This Contract shall begin upon execution by both parties or **,** (whichever is later) and end , inclusive.

B. Termination

1. **Termination at Will**

   This Contract may be terminated by either party upon no less than thirty (30) calendar days written notice, without cause, unless a lesser time is mutually agreed upon by both parties. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

2. **Termination Due To Lack of Funds**

   In the event funds to finance this Contract become unavailable, the Agency may terminate the Contract upon no less than twenty-four (24) hours written notice to the Vendor. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. The Agency shall be the final authority as to the availability of funds.

3. **Termination for Breach**

   Unless the Vendor's breach is waived by the Agency in writing, the Agency may, by written notice to the Vendor, terminate this Contract upon no less than twenty-four (24) hours written notice. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. If applicable, the Agency may employ the default provisions in Chapter 60A-1.006(4), Florida Administrative Code.

Waiver of breach of any provisions of this Contract shall not be deemed to be a waiver of any other breach and shall not be construed to be a modification of the terms of this Contract. The provisions herein do not limit the Agency's right to remedies at law or to damages.

C. Contract Managers

1. The Agency's Contract Manager's name, address and telephone number for this Contract is as follows:

   Enter Contract Manager's Name
   Agency for Health Care Administration
   Enter Street Address
   ,

2. The Vendor's Contract Manager's name, address and telephone number for this Contract is as follows:

   Enter Contract Manager's Name
   Enter Vendor Name
   Enter Street Address
   ,

3. All matters shall be directed to the Contract Managers for appropriate action or disposition. A change in Contract Manager by either party shall be reduced to writing through an amendment to this Contract by the Agency.

D. Renegotiation or Modification

1. Modifications of provisions of this Contract shall only be valid when they have been reduced to writing and duly signed during the term of the Contract. The parties agree to renegotiate this Contract if federal and/or state revisions of any applicable laws, or regulations make changes in this Contract necessary.

2. The rate of payment and the total dollar amount may be adjusted retroactively to reflect price level increases and changes in the rate of payment when these have been established through the appropriations process and subsequently identified in the Agency's operating budget.

E. Name, Mailing and Street Address of Payee

1. The name (Vendor name as shown on Page 1 of this Contract) and mailing address of the official payee to whom the payment shall be made:

   Enter Vendor Name
   Enter PO Box or Street Address
   ,

2. The name of the contact person and street address where financial and administrative records are maintained:

   Enter Contact Person's Name
   Enter Vendor Name
   Enter PO Box or Street Address
   ,

F. All Terms and Conditions

This Contract and its attachments as referenced herein contain all the terms and conditions agreed upon by the parties.

IN WITNESS THEREOF, the parties hereto have caused this page Contract, which includes any referenced attachments, to be executed by their undersigned officials as duly authorized. This Contract is not valid until signed and dated by both parties.

VENDOR: _____	**STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION**
SIGNED BY: _____	**SIGNED BY:** _____
NAME: _____	**NAME:** _____
TITLE: _____	**TITLE:** _____
DATE: _____	**DATE:** _____

FEDERAL ID NUMBER (or SS Number for an individual):

VENDOR FISCAL YEAR ENDING DATE:

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List of attachments included as part of this Contract:

Specify Type	Letter/ Number	Description (include number of pages)
Attachment		Scope of Services ( )
Attachment		Health Insurance Portability and Accountability Act of 1996 Compliance (2 Pages)
Attachment		( )
Attachment		( )
Attachment		( )
Attachment		( )
Attachment		( )

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ATTACHMENT B

BUSINESS ASSOCIATE AGREEMENT

The parties to this Attachment agree that the following provisions constitute a business associate agreement for purposes of complying with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Attachment is applicable if the Vendor is a business associate within the meaning of the Privacy and Security Regulations, 45 C.F.R. 160 and 164.

The Vendor certifies and agrees as to abide by the following:

1. Definitions. Unless specifically stated in this Attachment, the definition of the terms contained herein shall have the same meaning and effect as defined in 45 C.F.R. 160 and 164.

   1.a. Protected Health Information. For purposes of this Attachment, protected health information shall have the same meaning and effect as defined in 45 C.F.R. 160 and 164, limited to the information created, received, maintained or transmitted by the Vendor from, or on behalf of, the Agency.

   1.b. Security Incident. For purposes of this Attachment, security incident shall mean any event resulting in computer systems, networks, or data being viewed, manipulated, damaged, destroyed or made inaccessible by an unauthorized activity. See National Institute of Standards and Technology (NIST) Special Publication 800-61, "Computer Security Incident Handling Guide," for more information.

2. Use and Disclosure of Protected Health Information. The Vendor shall not use or disclose protected health information other than as permitted by this Contract or by federal and state law. The Vendor will use appropriate safeguards to prevent the use or disclosure of protected health information for any purpose not in conformity with this Contract and federal and state law. The Vendor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information the Vendor creates, receives, maintains, or transmits on behalf of the Agency.

3. Use and Disclosure of Information for Management, Administration, and Legal Responsibilities. The Vendor is permitted to use and disclose protected health information received from the Agency for the proper management and administration of the Vendor or to carry out the legal responsibilities of the Vendor, in accordance with 45 C.F.R. 164.504(e)(4). Such disclosure is only permissible where required by law, or where the Vendor obtains reasonable assurances from the person to whom the protected health information is disclosed that: (1) the protected health information will be held confidentially, (2) the protected health information will be used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and (3) the person notifies the Vendor of any instance of which it is aware in which the confidentiality of the protected health information has been breached.

4. Disclosure to Third Parties. The Vendor will not divulge, disclose, or communicate protected health information to any third party for any purpose not in conformity with this Contract without prior written approval from the Agency. The Vendor shall ensure that any agent, including a subcontractor, to whom it provides protected health information received from, or created or received by the Vendor on behalf of, the Agency agrees to the same terms, conditions, and restrictions that apply to the Vendor with respect to protected health information.

5. Access to Information. The Vendor shall make protected health information available in accordance with federal and state law, including providing a right of access to persons who are the subjects of the protected health information in accordance with 45 C.F.R. 164.524.

6. Amendment and Incorporation of Amendments. The Vendor shall make protected health information available for amendment and to incorporate any amendments to the protected health information in accordance with 45 C.F.R. § 164.526.

7. Accounting for Disclosures. The Vendor shall make protected health information available as required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528. The Vendor shall document all disclosures of protected health information as needed for the Agency to respond to a request for an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

8. Access to Books and Records. The Vendor shall make its internal practices, books, and records relating to the use and disclosure of protected health information received from, or created or received by the Vendor on behalf of the Agency, available to the Secretary of the Department of Health and Human Services or the Secretary's designee for purposes of determining compliance with the Department of Health and Human Services Privacy Regulations.

9. Reporting. The Vendor shall make a good faith effort to identify any use or disclosure of protected health information not provided for in this Contract. The Vendor will report to the Agency, within ten (10) business days of discovery, any use or disclosure of protected health information not provided for in this Contract of which the Vendor is aware. The Vendor will report to the Agency, within twenty-four (24) hours of discovery, any security incident of which the Vendor is aware. A violation of this paragraph shall be a material violation of this Contract.

10. Termination. Upon the Agency's discovery of a material breach of this Attachment, the Agency shall have the right to terminate this Contract.

    10.a. Effect of Termination. At the termination of this Contract, the Vendor shall return all protected health information that the Vendor still maintains in any form, including any copies or hybrid or merged databases made by the Vendor; or with prior written approval of the Agency, the protected health information may be destroyed by the Vendor after its use. If the protected health information is destroyed pursuant to the Agency's prior written approval, the Vendor must provide a written confirmation of such destruction to the Agency. If return or destruction of the protected health information is determined not feasible by the Agency, the Vendor agrees to protect the protected health information and treat it as strictly confidential.

The Vendor has caused this Attachment to be signed and delivered by its duly authorized representative, as of the date set forth below.

Vendor Name:

_____ _____

Signature Date

_____

Name and Title of Authorized Signer

AHCA Form 2100-0017 (Rev. JAN 05)

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ATTACHMENT C

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION CONTRACTS/SUBCONTRACTS

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, signed February 18, 1986. The guidelines were published in the May 29, 1987, Federal Register (52 Fed. Reg., pages 20360-20369).

INSTRUCTIONS

1. Each Vendor whose contract/subcontract equals or exceeds $25,000 in federal monies must sign this certification prior to execution of each contract/subcontract. Additionally, Vendors who audit federal programs must also sign, regardless of the contract amount. The Agency for Health Care Administration cannot contract with these types of Vendors if they are debarred or suspended by the federal government.

2. This certification is a material representation of fact upon which reliance is placed when this contract/subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, the Federal Government may pursue available remedies, including suspension and/or debarment.

3. The Vendor shall provide immediate written notice to the contract manager at any time the Vendor learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "debarred," "suspended," "ineligible," "person," "principal," and "voluntarily excluded," as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the contract manager for assistance in obtaining a copy of those regulations.

5. The Vendor agrees by submitting this certification that, it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this contract/subcontract unless authorized by the Federal Government.

6. The Vendor further agrees by submitting this certification that it will require each sub-vendor of this contract/subcontract, whose payment will equal or exceed $25,000 in federal monies, to submit a signed copy of this certification.

7. The Agency for Health Care Administration may rely upon a certification of a Vendor that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting/subcontracting unless it knows that the certification is erroneous.

8. This signed certification must be kept in the contract manager's contract file. Sub-vendor's certifications must be kept at the Vendor's business location.

CERTIFICATION

(1) The prospective Vendor certifies, by signing this certification, that neither he nor his principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal department or agency.

(2) Where the prospective Vendor is unable to certify to any of the statements in this certification, such prospective Vendor shall attach an explanation to this certification.

_____ _____

Signature Date

_____

Name and Title of Authorized Signer

AHCA Form 2100-0009 (JAN03)

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ATTACHMENT D

CERTIFICATION REGARDING LOBBYING
CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, 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 transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature	Date
Name of Authorized Individual	Application or Contract Number
Name and Address of Organization	

AHCA Form 2100-0010 (Rev. OCT02)

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ATTACHMENT E

CERTIFICATE OF COMPLIANCE
GENERAL TERMS OF COMPLIANCE

1. We shall comply with all terms and conditions of the Agency Standard Contract and shall furnish and deliver the services described in this Request for Proposal. The fee(s) proposed shall apply for the period of time stated in the REQUEST FOR PROPOSAL and cover all services required under the REQUEST FOR PROPOSAL for those services specified in our proposal.

2. We understand and agree that this proposal constitutes an offer which, when accepted in writing, shall constitute a valid and binding contract between the undersigned and the State of Florida.

3. We understand and agree that we have read the state's specifications provided in the REQUEST FOR PROPOSAL and that this proposal is made in accordance with the provisions of such specifications. By our written signature on this proposal, we guarantee and certify that all items included in this proposal shall meet or exceed any and all such state specifications. We further agree, if awarded a contract, to deliver services that meet or exceed specifications provided in the REQUEST FOR PROPOSAL.

4. We certify that this proposal is made without prior understanding, agreement, or connections with any corporation, firm, or person submitting a proposal for the same services and is in all respects fair and without collusion or fraud. We agree to abide by all conditions of the proposal.

5. We certify that we have received a copy of all inquiries, responses, amendments and/or addenda issued by the Agency related to this REQUEST FOR PROPOSAL.

6. We certify that no elected official or employee of the State of Florida has or will benefit financially or materially from our proposal or any contract that may result from the proposal except as specifically authorized in the REQUEST FOR PROPOSAL. We have disclosed in our proposal the name of any officer, director, or agent who is also an employee of the State of Florida or any of its agencies. Further we have disclosed in our proposal the name of any state employee who owns, directly or indirectly, an interest of five percent or more in our firm or any of its branches or subsidiaries.

7. We certify that we do not discriminate in our employment practices with regard to race, color, religion, age, marital status, political affiliation, national origin or handicap.

8. We understand that we and our subcontractors, if any, must be registered to do business in Florida at the time of contract award.

9. We comply with all confidentiality requirements specified in Florida law that pertain to any contract that may be awarded as a result of this REQUEST FOR PROPOSAL.

_____ _____

Name of Person Authorized to Bind the Company Title

_____

Name of Organization Submitting Proposal

_____

Address

_____

City, State, Zip

I certify that I am authorized to sign this proposal for the respondent.

_____ _____

Authorized Signature Date

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ATTACHMENT F

STATEMENT OF NO INVOLVEMENT

I, _____, as an authorized representative of

_____, certify that no member of this firm

nor any person having interest in this firm has been awarded a contract by the Agency

for Health Care Administration on a noncompetitive basis to:

(1) Develop this Request for Proposal;

(2) Perform a feasibility study concerning the scope of work contained in this RFP; or

(3) Develop a program similar to what is contained in this RFP.

_____
Authorized Representative

_____
Date

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ATTACHMENT G

AGENCY FOR HEALTH CARE ADMINISTRATION
Drug-free Workplace Certification

In the event of Identical or Tie Bids/Proposals: Preference shall be given to businesses with drug-free workplace programs. Whenever two or more bids which are equal with respect to price, quality, and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a bid received from a business that certifies that it has implemented a drug-free work place program shall be given preference in the award process. Established procedures for processing tied awards will be followed if none of the tied vendors have a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

1) Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.

2) Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.

3) Give each employee engaged in providing the commodities or contractual services that are under bid a copy of the statement specified in subsection (1).

4) In the statement specified in subsection (1), notify the employees that, as a condition of working on the commodities or contractual services that are under bid, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.

5) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program if such is available in the employee's community by, any employee who is so convicted.

6) Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

As the person authorized to sign the statement, I certify that this firm complies fully with the above requirements.

_____ _____

Signature Date

_____

Printed Name of Signer/ Title of Signer/ Company Name

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ATTACHMENT H

CORPORATE CORRESPONDENCE INDIVIDUAL

DATE: _____

VENDOR: _____

Procurement Represented By:

NAME: _____

ADDRESS: _____

_____

TELEPHONE: _____

FAX NUMBER: _____

SIGNATURE: _____

NOTE: This name and address will be used for future correspondence pertaining to this REQUEST FOR PROPOSAL and your proposal. Please print or type.

In order for your company's proposal to be considered in response to this specification, it is MANDATORY that this sheet be completed and returned with your proposal.

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ATTACHMENT I

CORPORATE REFERENCE FORM
Provide all information requested.

NAME OF VENDOR: _____

REFERENCE:

FIRM/AGENCY NAME: _____

ADDRESS: _____

_____

CONTACT PERSON: _____
NAME/TITLE

_____
PHONE NUMBER

PROJECT DATES: STARTED_____

COMPLETED_____

TITLE OF THE PROJECT:_____

START AND END DATES OF THE ORIGINAL CONTRACT:_____

TOTAL CONTRACT VALUE:_____

AVERAGE STAFF HOURS IN FTEs DURING OPERATIONS:_____

TRANSACTION PROCESSING VOLUME:_____

BRIEF DESCRIPTION OF SCOPE OF WORK:_____

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ATTACHMENT J

PERSONAL REFERENCE FORM
Provide all information requested.

NAME OF EMPLOYEE:_____

REFERENCE:
FIRM/AGENCY NAME:_____

ADDRESS:_____

_____

_____

CONTACT PERSON:
NAME/TITLE_____

_____
PHONE NUMBER

POSITION(S) OF INDIVIDUAL WITHIN THE PROJECT ORGANIZATION:

_____

_____

PROJECT DATES: STARTED_____ COMPLETED _____

BRIEF DESCRIPTION OF INDIVIDUAL'S RESPONSIBILITIES:

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ATTACHMENT K

ADDENDUM ACKNOWLEDGMENT FORM

This is to acknowledge receipt of Addendum _____ to RFP _____.

FIRM: _____

NAME: _____

ADDRESS: _____

_____

_____

TELEPHONE: _____ DATE: _____

SIGNATURE: _____

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ATTACHMENT L SUBCONTRACTOR UTILIZATION REPORT FORM FOR COMMODITIES/SERVICES

DIRECTIONS:

Vendors working for the Agency for Health Care Administration (AHCA) **must complete and submit this attachment with each invoice submitted for payment**. Questions regarding use of this form should be directed to the Agency's Contract Manager identified in the contract.

AHCA Contract No.:_____

Invoice Number:_____

Invoice Service Period:_____

☐ Check box if no minority subcontractors were used during this period.

LIST NAMES & ADDRESSES OF SUBCONTRACTORS UTILIZED THIS INVOICE PERIOD	SERVICE PROVIDED	LIST AMOUNT PAID TO EACH SUBCONTRACTOR THIS INVOICE PERIOD	INDICATE THE ONE CATEGORY THAT BEST DESCRIBES EACH ORGANIZATION LISTED																			
			BUSINESS CLASSIFICATION						CERTIFIED MBE (Supply Ethnic Code)					NON-CERTIFIED MBE (Supply Ethnic Code)					NON-PROFIT ORG.			
			NON-MINORITY - A	SMALL BUSINESS (STATE) - B	SMALL BUSINESS (FEDERAL) - C	GOVERNMENTAL AGENCY - E	NON-PROFIT ORGANIZATION - F	P.R.I.D.E. - G	AFRICAN AMERICAN - H	HISPANIC - I	ASIAN/HAWAIIAN - J	NATIVE AMERICAN - K	AMERICAN WOMAN - M	AFRICAN AMERICAN - N	HISPANIC - O	ASIAN/HAWAIIAN - P	NATIVE AMERICAN - Q	AMERICAN WOMAN - R	BOARD IS 51% OR MORE MINORITY - S	51% OR MORE MINORITY OFFICERS - T	51% OR MORE MINORITY COMMUNITY SERVED - U	OTHER NON-PROFIT - V

AHCA Form 2100-0039 (APR04)

ATTACHMENT L SUBCONTRACTOR UTILIZATION REPORT FORM FOR COMMODITIES/SERVICES, CONTINUED

AHCA Form 2100-0039 (APR04)

ATTACHMENT L SUBCONTRACTOR UTILIZATION REPORT FORM FOR COMMODITIES/SERVICES, CONTINUED

SUBCONTRACTOR UTILIZATION REPORT FORM CERTIFICATION:

I certify that the information provided in the preceding page is accurate as of the last day of the payment period identified on this form.

_____
(Signature) (Date)

_____
(Business Name)

_____
(Street Address)

_____
(City, State, Zip Code)

_____
(Phone Number)

AHCA Form 2100-0039 (APR04)

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APPENDIX A FLORIDA MEDICAID PROGRAM SUMMARY

A.1 Introduction

The state of Florida reimburses providers for the provision of medical services to eligible recipients under Title XIX (Medicaid) and Title XXI (State Children's Heath Insurance Program) of the Social Security Act. Services are provided through a combination of fee-for-service and pre-paid arrangements with a variety of medical and other providers and managed care programs.

Claims for payment received from medical providers are processed, adjudicated, and paid through a federally certified MMIS. The current MMIS has been operational since January 1989 and is certified for seventy-five percent (75%) federal financial participation (FFP).

A.2 Organizational Structure

The Agency for Health Care Administration is Florida's designated state agency responsible for the administration of the Florida Medicaid Program (Title XIX). The Governor appoints the Secretary of the Agency for Health Care Administration. The Agency was established on July 1, 1992, to consolidate health care financing, data collection, and regulatory functions into a single state agency. The Agency is responsible for health policy and cost control, Medicaid and health care regulation.

Within the Agency, the Medicaid program is administrated by the Deputy Secretary for Medicaid. The Medicaid Office is organized into the following organizational units: Program Analysis, Research, Contract Management, Medicaid Services, Medicaid Health Systems Development, Pharmacy and eleven (11) area Medicaid offices.

The Medicaid program integrity function is the responsibility of the Bureau of Medicaid Program Integrity, which reports to the Agency Inspector General. The Information Technology function is the responsibility of the Bureau of Information Technology which reports to the Deputy Secretary for Administrative Services.

The Agency organizational charts are provided in Appendix E.

A.3 Medicaid Program Description

A.3.1 Recipients

At the end of November 2004, 2,136,365 persons were eligible for Florida's Medicaid Program services. Recipient participation statistics are available in the procurement library.

Medicaid

There are two basic groups of people eligible for Medicaid: low income families and children, and the Aged, Blind and Disabled. Within these two groups, there are several categories of eligibility. In addition to qualifying under one of these two basic groups, an eligible Medicaid recipient must have met income and asset limits of a defined eligibility category. Income and asset limits vary by category.

The following are the categories for Medicaid eligibility in Florida:

- FAMILIES AND CHILDREN

Low Income Families include single parent families and families with a disabled or unemployed parent.

Foster Care, Adoption Subsidy and Emergency Shelter include dependent children in the care and control of the State and children with special medical needs whose adoption was supported by the State or a private adoption agency.

Public Medical Assistance (PMA) includes children in intact families and children born after September 30,1983, not living with relatives.

KidCare Medicaid provides mandatory Medicaid coverage for children ages 1 to 6, up to 133 percent of the poverty level; and children age 6 to 19 up to 100 percent of the poverty level.

Pregnant Women and Newborns includes pregnant women and infants up to 1 year to 150 percent of the poverty level. Infants up to 1 year are a mandatory group up to 185 percent of the poverty level. Optional coverage is provided for pregnant women from 150 to 185 percent and for infants from 185 to 200 percent of the poverty level.

Breast & Cervical Cancer Coverage (B&CC) is an optional program providing Medicaid coverage for treatment of breast and cervical cancer for uninsured women under age 65 up to 200 percent of the poverty level.

Medically Needy includes individuals whose income is too high to qualify for other Medicaid programs but who have large monthly medical bills. They are eligible for Medicaid on a month-to-month basis.

- AGED, BLIND AND DISABLED (SSI-RELATED)

Supplemental Security Income (SSI) eligibility is determined by the Social Security Administration. Individuals who receive SSI in Florida are automatically eligible for full Medicaid benefits. To be eligible for SSI, an individual must be age 65 or older or totally and permanently disabled, and meet the income and asset limits.

Medicaid for the Aged and Disabled (MEDS-AD) covers individuals who are age 65 or older or totally and permanently disabled, and have income less than 88 percent of the Federal Poverty Level and meet the asset limit.

Institutional Care (ICP) includes individuals requiring long-term institutional care or home and community-based waiver services.

Qualified Medicare Beneficiaries (QMB) entitles individuals who are enrolled or conditionally enrolled in Medicare Part A and whose incomes do not exceed 100 percent of the poverty level to receive Medicaid payment of their Medicare premiums, deductibles, and coinsurances.

Special Low-Income Medicare Beneficiaries (SLMB) entitles individuals to receive Medicaid payment of their Medicare Part B premium if they have income above 100 percent but not exceeding 120 percent of the Federal Poverty Level.

Part B Medicare Only Beneficiaries (QI-1) entitles individuals to receive Medicaid payment of their Medicare Part B premium if they have income above 120 percent but less than 135 percent of the Federal Poverty Level.

This group is 100 percent federally funded and is not an entitlement program.

Waiver, Nursing Home, and Hospice includes Medicaid services provided to aged/blind/disabled persons up to 222 percent of the poverty level.

Medically Needy includes individuals whose income is too high to qualify for other Medicaid programs, but who have large monthly medical bills. They are eligible for Medicaid on a month-to-month basis.

Refugees include aliens who are eligible under a special general assistance program.

- CATEGORIES WITH LIMITED MEDICAID BENEFITS

The following categories of Medicaid eligibility have limited Medicaid benefits:

Medically Needy recipients are not eligible for nursing facility services, intermediate care facilities for the developmentally disabled (ICF/DD) services, waiver services, assistive care, Sub-acute Inpatient Psychiatric Program services and Medicaid state mental hospital services.

Qualified Medicare Beneficiaries (QMB) are not eligible for any Medicaid services except for Medicaid payment of their Medicare premiums, deductibles and coinsurance.

Special Low Income Medicare Beneficiaries (SLMB) are not eligible for any Medicaid services except for Medicaid payment of their Part B Medicare premium.

Silver Saver Prescription Program provides up to $160 a month in prescription benefits to low-income seniors. There is a small co-pay

Presumptively Eligible Pregnant Women (PEPW) allows a woman to access prenatal care while Department of Children and Families' eligibility staff makes a regular determination of eligibility; they are only eligible for outpatient and office services.

Family Planning Waiver Services extends eligibility for family planning services for 24 months to postpartum women who have had a Medicaid-financed delivery or pregnancy-related service within two years prior to the date of losing Medicaid eligibility.

Emergency Medicaid for Aliens who meet all Medicaid eligibility requirements except for citizenship or alien status.

Medicaid providers are responsible for verifying a recipient's eligibility for a Medicaid service prior to providing the service.

Title XXI Children

As a result of the Balanced Budget Act of 1997 and other federal and state legislation, the State of Florida may opt to cover certain children, living in families whose income is up to two hundred percent (200%) of the poverty level (ages 0-1, up to 235%). In 1998 the Florida Legislature enacted the Florida KidCare program to provide Title XXI coverage to previously uninsured children. There are four distinct components:

- Medicaid – entitlement for children under age 21 whose family income qualifies them for services, as of June 2003, 1,183,774 including 1,497 infants under age 1
- MediKids – insurance for children ages 1 through 5 years; 33,384 as of June 2003
- Florida Healthy Kids – insurance for children ages 5 to 19 years; 264,198 as of June 2003

- Children's Medical Services Network – for children ages 1 to 19 years with special health care needs; 9,569 as of June 2003.

Approximately 1.5 million children are covered under the Florida KidCare program.

A.3.2 Providers

Currently the Florida Medicaid program maintains approximately 80,000 provider records. To be reimbursed for covered services provided to recipients, each provider must enroll and meet the requirements for a provider of that type. The requirements and policies applying to each provider type are found in the provider handbooks available in the procurement library. The Florida Medicaid Program currently enrolls the following provider types:

- Advanced Registered Nurse Practitioner (ARNP)
- Aging and Adult Services
- Air Ambulance Company
- Ambulance Company
- Ambulatory Surgical Center
- Assistive Care Services
- Audiologist
- Birthing Center
- Case Management Agency
- Children's Medical Services
- Chiropractor
- Community Behavioral Health Services
- County Health Department
- Crossover Physical Therapy
- Dental Lab
- Dentist
- Dialysis Center (Medicare crossovers only)
- Early Intervention Service (Professional and Paraprofessional)
- Family Planning
- Federally Qualified Health Center (FQHC)
- General Hospital (Inpatient and Outpatient)
- Health Maintenance Organization/Prepaid Health Plan
- Hearing Aid Specialist
- Home and Community-Based Services (HCBS) Provider
- Home Health Agency
- Hospice
- Infusion Pharmacy
- Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Private and State Facility
- Independent Laboratory
- Licensed Midwife
- Long Term Care Non-Community Pharmacy
- Medical Supplier/Durable Medical Equipment
- Medical Foster Care
- Multi-Load Private Transportation Carrier
- Non-Emergency Medical Vehicle Company
- Non-Profit Transportation Carrier

- Nursing Home
- Optician
- Optometrist
- Pharmacy
- Physician (DO)
- Physician (MD)
- Physician's Assistant
- Personal Care Provider
- Podiatrist
- Portable X-Ray Company
- Prepaid Mental Health Plan (PMHP)
- Private Transportation
- Psychiatric Inpatient Services
- Psychologist (crossover only)
- Public Transportation
- Registered Nurse
- Registered Nurse First Assistant
- Rural Health Clinic
- School District
- Skilled Nursing Unit
- Social Worker/Case Manager
- Special Hospital Outpatient Rehabilitation Center/Clinic (crossover only)
- Specialized Mental Health Practitioner (therapeutic foster care provider)
- Swing Bed Facility
- Taxi Company
- Therapist (speech, physical, occupational and respiratory)
- Vocational Rehabilitation Agency

A.3.3 Services

The Florida Medicaid Program covers all federally mandated services and a number of optional services.

Florida pays deductible and coinsurance for certain services covered by Title XVIII (Medicare) of the Social Security Act. Florida also pays the monthly premiums for Supplemental Medical Insurance (SMI), Medicare Part A for Qualified Medicare Beneficiaries (QMB), and Qualified Disabled Working Individuals (QDWI). Services covered are:

- Advanced Registered Nurse Practitioner
- Ambulatory Surgical Center
- Assistive Care Services
- Birthing Center Services
- Child Health Check-Up
- Child Health Services Targeted Case Management
- Chiropractic Services
- Community Mental Health Services
- County Health Department Clinic Services
- Dental Services – Children
- Dental Services - Adults
- Durable Medical Equipment and Supplies
- Early Intervention
- Federally Qualified Health Centers

- Freestanding Dialysis Center Services
- Hearing Services
- Hearing Services – Newborn Screening
- Home Health Care Services
- Hospice Care Services
- Hospital, Inpatient
- Hospital, Outpatient
- Independent Laboratory Services
- Intermediate Care Facility for the Developmentally Disabled (ICF/DD)
- Licensed Midwife Services
- Medical Foster Care Services
- Mental Health Targeted Case Management
- Nursing Facility Services
- Optometric Services
- Physician Services
- Physician Assistant Services
- Podiatry Services
- Portable X-Ray Services
- Prescribed Drug Services
- Prescribed Pediatric Extended Care (PPEC) Services
- Registered Nurse First Assistant Services
- Regional Perinatal Intensive Care Center (RPICC)
- Rural Health Services
- School-Based Services Programs - School District Program
- School-Based Services Programs – County Health Department Program
- Therapy - Occupational
- Therapy - Physical
- Therapy - Respiratory
- Therapy - Speech-Language Pathology
- Transplant Services – Organ and Bone Marrow
- Transportation Services
- Visual Services
- Waiver – Adult Cystic Fibrosis
- Waiver – Adult Day Health Care
- Waiver - Aged/Disabled Adult
- Waiver – Alzheimer's Disease
- Waiver - Assisted Living for the Elderly
- Waiver – Channeling
- Waiver – Consumer-Directed Care Research and Demonstration
- Waiver - Developmental Services
- Waiver – Family Planning
- Waiver – Healthy Start Coordinated Care System
- Waiver – Model Waiver Program
- Waiver - Nursing Home Diversion
- Waiver - Project AIDS Care
- Waiver - Sub-Acute Inpatient Psychiatric Program (SIPP)
- Waiver - Supported Living
- Waiver - Traumatic Brain Injury/Spinal Cord Injury

Program requirements for all the above services are documented in the Florida Administrative Code, the Medicaid State Plan, provider handbooks, and provider bulletins, which are available for review in the procurement library. Additional services may be added or deleted during the term of this contract due to changes in federal or state requirements.

A.3.3.1 Managed Care

Florida has developed managed care strategies to improve recipient access to care and continuity of care, while reducing the overall costs of that care. The state has the overall goal to enroll, with few exceptions, Medicaid recipients in either a Medicaid Health Maintenance Organization (HMO), MediPass (the state of Florida's primary care case management program), Prepaid Mental Health Plan, Prepaid Dental Health Plan, and PSNs (Provider Service Networks).

Since November 1996, Florida has developed choice counseling approaches to assist recipients in understanding managed care alternatives and deciding whether participation in one of these options meets their needs and circumstances. Medicaid contracts with a private company, Medicaid Options, to help recipients enroll or disenroll for Medicaid Managed Care programs. If Medicaid recipients do not choose a managed care option, they are assigned by the State to one of the locally available managed care options. Recipients who enroll with a managed care plan begin a 12-month enrollment period. They have 90 days to try the plan and request a change. After the initial 90 days, they must remain with their plan for the next nine months.

Only plan changes for "good cause" will be allowed during these nine months. Each 12 months thereafter, recipients will receive notification of their open enrollment period when they may change plans for the following year.

Recipients may change primary care providers within their current plans. To change their primary care provider, recipients should contact the program in which they are enrolled (the MediPass Area Medicaid Office, the HMO's member services office, or the PSN's enrollee services office, respectively).

Certain recipients are not bound to the 12-month enrollment period and are allowed to change their managed care plans at any time. These include:

- SSI recipients under age 19,
- Foster care children,
- Children in subsidized adoption arrangements,
- Children enrolled with Children's Medical Services,
- Dually eligible individuals (that is, eligible for both Medicare and Medicaid), and
- American Indians.

A.3.4 Claims and Claim-Related Transactions

Each provider bills on a prescribed paper claim form or electronic transaction. The information below lists the electronic transactions and paper claim forms currently used. Examples of paper claim forms are included in the Medicaid Procurement Library.

The ANXI X12 HIPAA transactions implemented by Florida Medicaid for electronic claims include:

- 270/271 Health Care Eligibility Benefit Inquiry and Response

- 276/277 Health Care Claims Status and Response
- 278 Health Care Services
- 820 Health Plan Premium
- 834 Benefit Enrollment and Maintenance
- 835 Claims Payment and Remittance
- 837P Professional Health Care Claim.
- 837I Institutional Health Care Claim
- 837D Dental Health Care Claim
- Retail Pharmacy Drug Claims - The National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide, Version 5 Release 1, September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1 Release 1, February 1, 1996.

The paper claim forms currently used are:

- Inpatient/Outpatient Hospital (UB-92)
- Monthly Institutional (021)
- Practitioner (CMS-1500)
- Non Institutional/Other (081)
- Dental (111)
- Emergency Transportation (131)
- Non-Emergency Transportation (131A)
- Public Transportation (141)
- NCPDP Universal Pharmacy Claim Form

The current fiscal agent also processes tape billings from physicians, pharmacies, clinics, and hospitals and receives Medicare crossover claims on tape from Blue Cross/Blue Shield of Florida and several other Medicare contractors. Claims are submitted electronically from providers via dial-up modems with 2400 and above baud rates for IBM compatible PCs. Additionally, the fiscal agent receives claims from providers via mainframe-to-mainframe transmissions. Pharmacy providers can also submit claims electronically via the Point-of-Service (POS) system. The Agency receives approximately one hundred forty (140) million claims annually and about ninety-three percent (93%) are received electronically.

A.4 Overview of Present Operation

A.4.1 Fiscal Agent Operations

The Medicaid fiscal agent operations are housed in approximately 50,000 square feet of space located at 2308 Killearn Center Boulevard, Tallahassee, Florida. The Medicaid Contract Management unit, with a staff of approximately fifty-one (51) full-time equivalent positions, occupies space contiguous to the fiscal agent space. All fiscal agent activities are located at this site with the exception of its mainframe processing activities and the Pharmacy Benefit Management function. A list of the hardware and software currently being used by the fiscal agent as part of their fiscal agent operations is provided in Appendix F.

The incumbent fiscal agent employs a total of about three hundred (300) people in Tallahassee to operate the FMMIS. Fiscal agent workload statistics are included in Appendix H and an organizational chart is in Appendix I. The current contract requires forty (40) systems group, technical staff and eight (8) ad hoc programmers to be located in Tallahassee. This staff is also responsible for Customer Service Requests (CSRs). A listing of outstanding CSRs is provided in the proposer library.

The incumbent DSS contractor employs a total of 12 people in Tallahassee to operate the DSS.

The current fiscal agent operation supports approximately 2.1 million recipients, and about 80,000 providers records with an average of about 140 million annual claims. Estimated annual Medicaid payments to providers are $14.1 billion.

Approximately ninety-three percent (93%) of the claims are received electronically; leaving about seven percent (7%) to be imaged and key entered. Over two million pharmacy POS claims are received monthly, with the heaviest volume at the first of the month due to Florida's monthly limit on pharmacy prescriptions and nursing home claims. A more detailed list of statistics is included in the current contractor's weekly statistical report included in the procurement library.

Fiscal agent provider relations staff support an estimated 90,000 telephone calls monthly. Telephone inquiries are received for the following major reasons: sixty-two percent (62%) claims status; twenty-six percent (26%) recipient eligibility; and twelve percent (12%) miscellaneous. Approximately 400,000 calls are received monthly through the Automated Voice Response System (AVRS) for eligibility and check payment status.

Telecommunications support is provided to state agencies via leased lines. The current fiscal agent's telecommunications network is described in Appendix F.

A.4.2 Fiscal Agent Functions

Whereas the details of scope of work and contractor responsibilities for the fiscal agent contract are provided in Sections 40 and 50, the following information is included to give the proposers a broad overview of the current fiscal agent functions.

1. Maintain computer programs and data files for all FMMIS operations.
2. Provide and maintain telecommunication link between Contractor and State computers.
3. Provide certain hardware and software for use by State staff.
4. Perform claims processing activities.
5. Perform provider relations activities.
6. Maintain the Medicaid Eligibility Verification System (MEVS).
7. Maintain the Automated Voice Response System (AVRS).
8. Maintain Plastic Medicaid ID cards generation and mailing system.
9. Maintain Point-of-Service (POS) system for submission and adjudication of pharmacy claims on-line.
10. Maintain Electronic Claims Submission (ECS) system.
11. Provide field representatives for provider relations support.
12. Provide Pharmacy Clinical Call Center.
13. Provide ad hoc reporting function for the State staff.
14. Make all provider disbursements.

15. Serve as records custodian for claims and other FMMIS related data and respond to requests for information with specific authorization by the State.
16. Enrollment and re-enrollment of providers.
17. Provide interfaces between FMMIS and other electronic data processing systems.
18. Generate reports and recipient Explanation of Medicaid Benefits.
19. Provide data entry services.

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APPENDIX B GLOSSARY OF TERMS

AD HOC REQUEST – A request to provide non-production reports.

ADJUDICATE – To determine whether all program requirements have been met and whether the claim can be paid, denied or suspended or the encounter data would be paid or denied.

ADJUDICATED CLAIM – A claim that has reached final disposition such that it can either been paid or denied or determined if it would be paid or denied.

ADJUSTMENT – A transaction that changes any payment information on a previously paid claim.

AGENCY – Agency for Health Care Administration

AHCA – Agency for Health Care Administration

AID CATEGORY – An alpha and numeric code identifying the criteria used to determine an individual's eligibility.

APD – Advanced Planning Document

ARNP – Advanced Registered Nurse Practitioner

ASA – Average Speed of Answer

ASN – ALTERNATIVE SERVICE NETWORK – A network of providers under separate contract to provide services to a list of Medicaid recipients and share in cost-savings for efficient patters of care.

AVRS – COMPUTERIZED AUTOMATED VOICE RESPONSE SYSTEM – Used to supply recipient eligibility information or claims status to providers via telephone.

BACKBONE – Cat5 and Gigabit Cabling, Multi mode Fiber Optics or combination of both Ethernet and Gigabit switches.

BENDEX – BENEFICIARY DATA EXCHANGE SYSTEM – A file containing data from the federal government regarding all persons receiving benefits from the Social Security Administration.

BESST – BENEFICIARY ENROLLMENT SOFTWARE AND SYSTEMS TECHNOLOGY – It is the incumbent Fiscal Agent (ACS) choice counseling system where Medicaid recipients' managed care choices are recorded.

BIDDER – A Vendor who returns a properly completed bid in response to a request for solicitation from an authorized state or agency-purchasing agent.

BUYER – An entity that has released the solicitation.

BUY-IN – A procedure whereby the state pays a monthly premium to the Social Security Administration on behalf of eligible Medicaid recipients, enrolling them in the Medicare Title XVIII Part A and Part B Program.

CALENDAR DAY – A twenty-four (24) hour period between midnight and midnight, regardless of whether or not it occurs on a weekend or holiday.

CALENDAR YEAR – A twelve (12) month period of time beginning on January 1 and ending on December 31.

CAN – Used to express non-mandatory provisions; words denote the permissive.

CAPS – Limits on services available to a Medicaid recipient, such as the number of dentures a recipient may receive.

CARRIER – An organization processing Medicare Part B claims on behalf of the federal government.

CBT – COMPUTER BASED TRAINING – Formal course materials delivered thorough an interactive web-based training application.

CDT – Current Dental Terminology

CERTIFICATION – The written acknowledgment by CMS that the operational MMIS meets all legal and operational requirements necessary for 75% Federal Financial Participation (FFP).

CFR – CODE OF FEDERAL REGULATIONS – The federal rules that direct the state in its administration of the Medicaid program and implementation and operation of an MMIS.

CHAMPUS – CIVILIAN HEALTH AND MEDICAL PROGRAM UNIFORMED SERVICE - The US Government program to that provided insurance to military dependents and retirees, now replaced by TRICARE.

CHCUP – CHILD HEALTH CHECK-UP – Formerly (EPSDT) Early, Periodic, Screening, Diagnosis and Treatment.

CIA – Certified Internal Auditor

CLAIM – A request for Medicaid to pay for health care services.

CLIA – THE CLINICAL LABORATORY IMPROVEMENT AMENDMENTS – Provisions of 1988 which requires all laboratory testing sites to obtain either a certificate of waiver or a certificate of registration along with an identification number in order to legally perform testing anywhere in the United States.

CMM – CAPABILITY MATURITY MODEL – An Information Technology (IT) system development methodology developed and promoted by Carnegie Mellon University to measure and certify the methods and controls used by a company or agency in the development of IT systems.

CMS – CENTERS FOR MEDICARE AND MEDICAID – The organizational unit of the U.S. Department of Health and Human services responsible for administration of the Title XIX Program under the Social Security Act.

CMS – Children's Medical Services Network

CNHDP – Community Nursing Home Diversion Pilot (more commonly known today as the Nursing Home Diversion waiver)

COB – Coordination of Benefits

COBC – Coordination of Benefits Contractor

COMPOUND DRUG – A medication that is a combination of two or more pharmaceuticals.

CONTRACT – The written, signed agreement resulting from, and inclusion of, this RFP, any subsequent amendments thereto and the proposer's proposal.

CONTRACT AMENDMENT – Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract; it shall include bilateral actions, such as administrative changes, notices of termination, and notices of the exercise of a contract option.

CONTRACT MANAGER – The state individual responsible for providing overall project direction, act as liaison between contractor and Medicaid staff and monitors contractor performance.

CONTRACTOR – The successful proposer (fiscal agent) with which the state has executed a contract that processes and adjudicates provider claims on behalf of the state.

COOP – CONTINUITY OF OPERATIONS PLAN – A plan that incorporates disaster recovery, risk analysis and contingency planning to assure continued operation of fiscal agent responsibilities in case of a disaster, system failure, work stoppage, or other occurrence

COST BASED REIMBURSEMENT – Reimbursement based on the provider's actual costs for rending serviced to Medicaid recipients. Some providers who are reimbursed on a cost basis are: county health department clinics, Federally Qualified Health Centers, and Rural Health Clinics.

COTS – Commercial-Off-The-Shelf

COVERED SERVICE – Mandatory medical services required by CMS and optional medical services approved by the State for which enrolled providers will be reimbursed for services provided to eligible Medicaid recipients.

CPA – Certified Public Accountant

CPT – CURRENT PROCEDURE TERMINOLOGY – Unique coding structure scheme for all medical procedures approved by the American Medical Association - Fourth Edition.

CROSSOVER CLAIM – A claim submitted by a Medicare/Medicaid provider to a Medicare carrier or intermediary on behalf of a dual Medicare/Medicaid eligible or Qualified Medicare Beneficiary that has been paid by Medicare and crossed over to Medicaid for payment of the Medicare deductible and/or coinsurance.

CSR – CUSTOMER SERVICE REQUEST – An official notification to the fiscal agent to initiate a deficiency, modification or additional requirement in the FMMIS.

CTI – Computer Telephone Integration

DAY – Calendar day, unless specified as a workday.

DCF – DEPARTMENT OF CHILDREN AND FAMILIES – DCF is the Florida agency that determines Medicaid eligibility in many categories and operates the FLORIDA System to record Medicaid eligibility and eligibility for other state assistance programs.

DEA – Drug Enforcement Agency

DELIVERABLE – All software, documentation, reports, manuals, and any other item that the Vendor is required to produce and/or tender to the state under terms and conditions of this contract.

DENIED CLAIM – A claim for which no payment is made to the provider because the claim is for non-covered services, is for an ineligible provider or recipient, is a duplicate of another similar or identical transaction, or does not otherwise meet State standards for payment.

DFS – Department of Financial Services (State of Florida)

DIAGNOSIS – The classification of a disease or condition.

DIP – DETAILED IMPLEMENTATION PLAN – A document that clearly and specifically defines each task and subtask and specifies a completion date.

DISASTER RECOVERY AND BACK-UP PLAN – A plan to ensure continued claims processing through adequate alternative facilities, equipment, back-up files, documentation and procedures in the event that the primary processing site is lost to the contractor.

DMO – Disease Management Organizations

DOAH – Department of Administrative Hearings (State of Florida)

DOEA – Department of Elder Affairs (State of Florida)

DRG – Diagnosis Related Group

DRUG REBATE – Program authorized by the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) in which legend drug manufacturers or labelers enter into an agreement with the Secretary, DHHS, to provide financial rebates to states based on dollar amount of their drugs reimbursed by the Medicaid program.

DSS – DECISION SUPPORT SYSTEM – Component of a data warehouse that provides analytical-level queries and reporting.

DUR – DRUG UTILIZATION REVIEW – Drug Utilization review is a process whereby the pharmacist reviews the prescription and the patient record for therapeutic appropriateness.

EAGLE – ESTATE AND CASULTY ACCOUNTING REPORTING SYSTEM – An application used by Third Party Liability to track activity in recovering Medicaid funds from Medicare, casualty cases, commercial carriers, and estate.

ECS – ELECTRONIC CLAIMS SUBMISSION – Electronic methods of claims submission.

ED – Emergency Department (DSS)

EDB – Medicare Enrollment Database

EDIT – Validation of data.

EDP – Electronic Data Processing

EFT – ELECTRONIC FUNDS TRANSFER – The payment of funds made by direct deposit to a provider's bank account.

EHR – ELECTRONIC HEALTH RECORD – (See also EMR, Electronic Medical Record), a record of diagnoses, treatments and laboratory results stored in an electronic record for retrieval and use by authorized treatment professionals

EIS – EXECUTIVE INFORMATION SYSTEM – High level management reporting using graphical and tabular reports via the Decision Support System (DSS) to provide upper management data for accessing the overall scope and performance of the Medicaid program.

ELIGIBILITY FILE – A file that maintains pertinent data for each Medicaid eligible recipient.

ELIGIBILITY VERIFICATION – Refers to the process of validating whether an individual is determined to be eligible for health care coverage through the Medicaid program and/or a provider is qualified to provide services to the Medicaid population. Eligibility for the recipient and provider is determined by the State.

EMR – ELECTRONIC MEDICAL RECORD (See also EHR, Electronic Health Record), a record of diagnoses, treatments and laboratory results stored in an electronic record for retrieval and use by authorized treatment professionals

ENCOUNTER DATA – Detailed data about individual health care related services provided by a capitated managed care organization (MCO) or other State designated managed care providers. Encounter data is equivalent to a standard Medicaid claim except that it is submitted to provide service delivery data to the Agency and is not eligible for reimbursement. MCO health care related services are those covered and reimbursed by a per member per month capitated rate payment.

ENHANCEMENTS – Major MMIS system changes that are federally or state mandated and funded by CMS at an enhanced rate.

EOB – EXPLANATION OF BENEFITS – An explanation of denial or reduced payment included on the provider's remittance advice.

EOMB – EXPLANATION OF MEDICAL BENEFITS – The result of Medicare claims processing reported to a provider.

EOMB – EXPLANATION OF MEDICAID BENEFITS – a report of paid Medicaid claims reported to selected recipients for fraud and abuse purposes.

EQRO – External Quality Review Organization

EVALUATION – The in-depth review and analysis of contractor's proposals.

FA – FISCAL AGENT – Refers to the Vendor operating the FMMIS. A contractor who processes Medicaid provider claims for payments and performs certain other related functions as an agent for the State.

FACTS – FRAUD AND ABUSE TRACKING SYSTEM – Developed by third party Vendor and used by Medicaid Program Integrity.

FAD – Fraud and Abuse Detection

FDLE – Florida Department of Law Enforcement

FFS – FEE FOR SERVICE – A case management fee.

FFP – FEDERAL FINANCIAL PARTICIPATION – The percentage amount contributed by the federal government towards a category of costs in the Florida Medicaid program.

FHK – Florida Healthy Kids

FLORIDA – Florida On-Line Recipient Integrated Data Access System – An integrated automated system for TANF, Food Stamps, Medicaid Eligibility, Child Support Enforcement, and Project Independence.

FMMIS – FLORIDA MEDICAID MANAGEMENT INFORMATION SYSTEM – Florida Medicaid claims processing system.

FMMIS/DSS – FLORIDA MEDICAID MANAGEMENT INFORMATION SYSTEM/DECISION SUPPORT SYSTEM – The MMIS and DSS designed, developed, and implemented by the Contractor to meet all of the business requirements contained in this RFP.

FRAES – Old facility licensure system replaced by LicenseEase. FRAES is a comprehensive database management system that offers the functionality to handle vast and complex data. This single application is designed to manage all phases of licensing, including complaint, inspection, legal cases and revenue management. This system also handles MediPass credentialing.

FREEDOM – FLORIDA RAPID ENTRY TO DATA ONLINE FOR MEDICAID – Name associated with current Medicaid DSS.

FTE WORKDAY – FTE workday is a unit of measurement that describes the eight hours a full time employee works in a day.

FTP – File Transfer Protocol

FUNCTIONAL EQUIVALENCE – The ability of a solution not defined in the federal General System Design (GSD) for Medicaid systems to meet the business requirements of the GSD.

FY – FISCAL YEAR – State: the twelve (12) month period beginning July 1 and ending June 30. Federal: the twelve (12) month period beginning October 1 and ending September 30.

GAAP – Generally Accepted Accounting Principles

GIS – GEOGRAPHICAL INFORMATION SYSTEMS – Software program that allow data to be displayed spatially.

GSD – GENERAL SYSTEM DESIGN – Defines the major feature and functions of an automated system to include major system logic, reports, screens, and input forms and files required for a certifiable MMIS.

GUI – Graphical User Interface

HCPCS – HEALTHCARE COMMON PROCEDURE CODING SYSTEM – A coding system designed by CMS that describes the physician and non-physician patient services covered by Medicaid and Medicare Programs and used primarily to report reimbursable services provided to patients.

HIPAA – THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 – A federal law that includes requirements to protect patient privacy, to protect security of electronic medical records, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers.

HIPP – Health Insurance Premium Payment

HME – AHCA Home Medical Equipment Unit

HQA – HEALTH QUALITY ASSURANCE – The Agency for Healthcare Administration’s bureau of Health Quality Assurance and Managed Care Administration.

HTML – HYPERTEXT MARKUP LANGUAGE – A standardized computer language for displaying information in Web browser screens across various operating systems and platforms.

ICD-9-CM – INTERNATIONAL CLASSIFICATION OF DISEASE, NINTH EDITION, CLINICAL MODIFICATION – A classification and coding structure of diseases used by the state and health care community to describe patients' conditions and illnesses and to facilitate the collection of statistical and historical data.

ICF/DD – Institutional Care Facility For The Developmentally Disabled

ICN – IMAGE CONTROL NUMBER – A unique serial number applied to each imaged document stored in FMMIS/DSS. Several ICNs may be associated with a single Transaction Control Number and non-claim documents may have an ICN as their sole control number.

ID – Identification number

IEVS – Income Eligibility Verification System

IG – Inspector General's Office (State of Florida)

IMMEDIATELY – Within one hour

IRS – Internal Revenue Service (Federal)

INTERMEDIARY – Private insurance organization under contract with the federal government handling Part A Medicare claims.

ISDM – INFORMATION SYSTEMS DEVELOPMENT METHODOLOGY – A formal process to organize, execute, and document the development of information systems projects, approved by the State to manage the work and produce artifacts appropriate to the platforms being used for development.

IT – INFORMATION TECHNOLOGY – Any equipment, or interconnected system(s) or subsystem(s) or equipment, that is used in the automatic acquisition, storage, manipulation, management, movement, control, display, switching, interchange, transmission, or reception of data or information by the Agency. IT includes computers, ancillary equipment, software, firmware, and similar procedures, services (including support services), and related resources.

J2EE - JAVA 2 PLATFORM, ENTERPRISE EDITION or J2EE- A Standard for developing distributed Multi-tier architecture applications, based on modular components running on an application server. It uses several technologies, including JDBC and CORBA, and extends their functionality with Enterprise Java Beans, Java Servlets, Java Server Pages and XML technologies.

JAD – Joint Application Design

JCA **-** J2EE CONNECTOR ARCHITECTURE - A standard that allows J2EE (Java 2 Platform, Enterprise Edition) application servers to reach enterprise information systems (EIS).

JMS - THE JAVA MESSAGE SERVICE - API is a messaging standard that allows application components based on the Java 2 Platform, Enterprise Edition (J2EE) to create, send, receive, and read messages. It enables distributed communication that is loosely coupled, reliable, and asynchronous.

JUKEBOX – A device that holds multiple optical discs and one or more disc drives, and can swap discs in and out of the drive as needed. The robotics mechanism, in simple terms, works just like a CD auto-changer. The optical disk is a "once write multiple reads" compact disc.

LAN – LOCAL AREA NETWORK – Backbone and Network Servers

LicenseEase – A new facility licensure system in 2002, which replaced FRAES. It manages all phases of licensing, including complaint, inspection, legal cases and revenue management. This system also handles MediPass credentialing.

LMS – Learning Management System

LOCK-IN – An FMMIS/DSS function that a Medicaid recipient receives certain benefits from a single, identified source. Lock-in is most used in Pharmacy Benefits Management to require a potentially abusive recipient to pick up prescriptions at a certain pharmacy only. Lock-in is used in managed care to require a recipient to receive care through a certain HMO or service network for a set period of time.

LTC – Long Term Care

MANAGED CARE – Systems of care designed to improve recipients' access to health care and continuity of care, while reducing the overall costs of care.

MARS – Management and Administrative Reporting Subsystem

MCO – MANAGED CARE ORGANIZATIONS – Specific to Florida Medicaid, these organizations include the current and future HMO plans along with the following specialized pre-paid service plans: Prepaid Mental Health Plan, Prepaid Dental Health Plan, Nursing Home Diversion waiver program, Exclusive Provider Organization. It is expected that the number and type of Florida Medicaid MCOs will continue to grow.

MDS – Minimum Dataset

MEDICAID – The federal medical assistance program as described in Title XIX of the Social Security Act.

MEDICAID REFORM – Proposed reform efforts to contain the cost of the Medicaid program in Florida.

MEDICARE – The federal health care program as described in Title XVIII of the Social Security Act. Part A covers hospitalization and Part B covers medical insurance.

MediPass – MEDICAID PHYSICIAN ACCESS SYSTEM – A Medicaid primary care case management program designed to assure adequate access to primary care, reduce inappropriate utilization, and control program costs.

MEVS – Medicaid Eligibility Verification System

MFCU – MEDICAID FRAUD CONTROL UNIT – A section under the Florida Attorney General that investigates potential Medicaid fraud and abuse.

MILESTONE – The measuring point used to review and approve progress, to authorize continuation of work, and, depending on the terms of the contract, to pay for work completed.

MIS – Managed Information System

MITA – MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE – An initiative by the federal Centers for Medicare and Medicaid Services to modernize Medicaid Management Information Systems operated by the states by promoting greater interoperability with other systems, use of Commercial-Off-The-Shelf software, reusable programs and systems, and system analysis that allows business needs to drive system development.

MMA – Medicare Prescription Drug, Improvement and Modernization Act of 2003

MMIS – MEDICAID MANAGEMENT INFORMATION SYSTEM – Medicaid claims processing and information system.

MODIFICATION – Routine FMMIS system changes that are identified throughout the life of the contract, documented on the Customer Service Request (CSR) form, and submitted to the contractor for design, programming, and implementation.

MPI – MEDICAID PROGRAM INTEGRITY – Unit responsible for Fraud and Abuse Detection under the Inspector General's Office.

MPN – Minority Physician Network

MQC – Medicaid Quality Control

MSAS – MEDICAID SERVICE AUTHORIZATION SYSTEM – Agency-developed tracking system for handling all service authorizations. Medicaid Area Offices use this system to track all requested and approved service authorizations.

.NET – (pronounced dot-net) - An initiative by Microsoft to create a new software development platform focused on network transparency, platform independence, and rapid application development.

NCPDP – National Council of Prescription Drug Programs

NDC – National Drug Code

NPDB – National Practitioner Database

NPI – National Provider Identification

NPS – National Provider System

OIR – Office of Insurance Information

ONLINE – Interaction between a user operating a cathode ray tube (CRT), personal computer, or point of service (POS) device to send and receive information on a video display via a telecommunications network to a central computer processing unit (CPU).

OSCAR – ONLINE SURVEY CERTIFICATION & REPORTING – The federal file which contains CLIA certified providers and their classifications. The interface loads and verifies the CLIA provider number, status and specialties for which a provider is approved and can deny claims based upon CLIA specialties and subspecialties found on the OSCAR file

OVERPAYMENT – Payment made to a provider in excess of the amount allowed under the Medicaid State Plan guidelines.

PAID CLAIM – A claim that has resulted in the provider being reimbursed for some dollar amount or a zero paid amount.

PBM – Pharmacy Benefit Management. (Same as PDCS)

PCCM – Primary Care Case Management

PCP – Primary Care Physician or Primary Care Providers

PDCS – PRESCRIPTION DRUG CARD SYSTEM – Claims processing system used by the incumbent fiscal agent to process all pharmacy claims with nightly data passed to FMMIS. (Same as PBM.)

PDHP – Prepaid Dental Health Plan

PDL – Preferred Drug List

PHP – Prepaid Health Plan

PMA – Public Medical Assistance

PMATF – Public Medical Assistance Trust Fund

PMBOK™ – THE PROJECT MANAGEMENT BODY OF KNOWLEDGE – A library of project management skills, tools and standards used by the Project Management Institute to measure and certify Project Management Professionals.

PMHP – PREPAID MENTAL HEALTH PROGRAM – A waiver program to capitate costs of certain mental health services currently operated in two AHCA areas.

PMI – PROJECT MANAGEMENT INSTITUTE – A body that certifies Project Management Professionals

PMP – Project Management Professional

POS – PLACE OF SERVICE – Sometimes used to mean "Point of Sale" for Pharmacy.

PRIME CONTRACTOR – A contractor who contracts directly with the state for performance of the work specified in this RFP.

PRO – Peer Review Organization

PROCUREMENT LIBRARY – The collection of FMMIS documentation, provider policy manuals, and general information related to the Florida Medicaid program and the Florida MMIS.

PROVIDER – A person, organization or institution that provides health care related services and is enrolled in the Florida Medicaid program.

PROVIDER CLASS – An extrapolation of provider type, category of service, geographic location and other factors that specify the characteristics used to distinguish different kinds of providers in the system.

PROVIDER HANDBOOK – Provider manuals that contain the State's program specific coverage, limitation, and reimbursement policies.

PSN – PROVIDER SERVICE NETWORK – A network of providers under separate contract to provide services to a list of Medicaid recipients and share in cost-savings for efficient patterns of care.

RBRVS – Resource Based Relative Value Scale

RECIPIENT – A person who has been determined to be eligible for assistance in accordance with the state plan(s) under Title XIV and Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, and/or Title IV of the immigration and Nationality Act.

REIMBURSEMENT HANDBOOK – Provider manuals that contain billing instruction for reimbursement by Florida Medicaid.

REJECTED CLAIM – A claim that contains errors found during screening such as missing provider ID or other key data elements, or has some conflicting information that will impede the proper adjudication through the automated system. Such claim is returned to the responsible provider without entering it into the FMMIS.

REMITTANCE VOUCHER – The statement mailed to a provider detailing the claim charges pending, paid, or denied. A summary of payments produced by MMIS along with provider reimbursement; RVs are sent to providers along with checks or EFT.

REPLACEMENT MEDICAID SYSTEM – FMMIS/DSS – The term used in this RFP to describe the new system that the contractor is to develop for the State of Florida; the system must be certifiable as meeting the requirements of Section 1903(r) of the Social Security Act.

RFP – REQUEST FOR PROPOSAL – The document that describes to prospective proposers the requirements of the fiscal agent, FMMIS, terms and conditions and technical information.

RetroDUR – Retroactive Drug Utilization Review

RV – Remittance Voucher

SCRUB – Remove an EFT record from the weekly payment file, essentially voiding the payment.

SDX – STATE DATA EXCHANGE SYSTEM – The social security administration's method of transferring SSI entitlement information to the state via tape.

SERVICE AUTHORIZATION – The approval required from a designate authority for reimbursement for certain Medicaid services.

SOA – Service Oriented Architecture

SOAP - SOAP (Simple Object Access Protocol) - A light-weight protocol for exchanging messages between computer software, typically in the form of software componentry. The word object implies that the use should adhere to the object-oriented programming paradigm.

SOLQ – State Online Query

SSA – SOCIAL SECURITY ADMINISTRATION – The federal organizational unit within DHHS that determines Medicaid eligibility for various federally-administered programs.

SCOPE OF WORK – A document prepared by the requestor and included in the requisition package, which delineates and fully describes the service to be performed or the required end result.

SOURCE SYSTEMS – Systems or data files outside FMMIS/DSS that supply data to FMMIS/DSS to be used in various business processes. There are many source systems, including the FLORIDA System operated by the Department of Health, BENDEX and SSX data from the Social Security Administration.

SPEND DOWN – The Medically Needy program requires that an individual incur medical expenses equal to his/her share of cost amount, a.k.a. spend down amount, in order to become eligible for Medicaid. Medicaid is federally prohibited from reimbursing providers any portion of a recipient's spend down amount, however share of the cost information and medical expenses are currently tracked on the state's welfare eligibility system.

STATUTES – Laws passed by Congress or a state legislature and signed by the President or the Governor of a state, respectively, that are codified in volumes called "codes" according to subject matter.

SUBCONTRACTOR – Any entity contracting with the Prime Contractor to perform services or to fulfill any of the requirements requested in this RFP or any entity that is a subsidiary of the Prime Contractor that performs the services or fulfills the requirements requested in this RFP.

SURS – SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM – Part of the current FMMIS but was replaced by a client service application and data mart in the DSS in 2001.

SVES – State Eligibility Verification System

SYSTEM DOCUMENTATION – Documents that contain the technical description of the configuration, components and operation of the FMMIS or DSS.

TAD – TURN AROUND DOCUMENT – A process and form used in the current FMMIS to receive Nursing Home rosters and claims, to be replaced with a Web portal function in FMMIS/DSS.

TCN – TRANSACTION CONTROL NUMBER – An internal control number assigned to each claim as the fiscal agent for processing receives it. The TCN is used in both FMMIS and PBM and is different in PBM.

TPA – Third Party Administrator

TPL – THIRD PARTY LIABILITY – A situation in which a claim submitted as a result of an accident or injury where another individual or organization may be responsible for payment or in which a recipient has health insurance resources other than Medicaid or Medicare which are responsible for at least partial payment of a claim. The TPL Subsystem identifies claims where liability potentially exists.

TRICARE – The US Government program that provides insurance to military dependents and retirees. (Previously known as CHAMPUS)

UAT – User Acceptance Testing

UCF – UNIVERSAL CLAIM FORM – The NCPDP standard paper claim form for pharmacy claims.

UPIN – Universal Provider Idenifier

USER – Any individual or a group identified by the state as the persons authorized to use all or parts of FMMIS functions. A User could also be a DSS User.

VENDOR – Any responsible source that provides a supply or service.

WAN – WIDE AREA NETWORK – Connection between two LANs.

WBS – WORK BREAKDOWN STRUCTURE – A detailed plan used to complete and track a project. The WBS identifies every task in the project, estimates time and resource requirements, identifies predecessor and successor tasks, identifies the critical path, and is used to compare to actual project performance

WORKDAY – A day scheduled for regular State of Florida employees to work; Monday through Friday except holidays observed by regular State of Florida employees. Timeframes in the RFP requiring completion with a number of workdays shall mean by 5:00 p. m. Eastern time on the last workday.

XML – EXTENSIBLE MARKUP LANGUAGE – Designed to improve the functionality of the Web by providing more flexible and adaptable information identification. XML is actually a metalanguage-a language for describing other languages-which allows users to design their own customized markup languages for limitless different types of documents.

XSL/XSLT - A language for transforming XML documents into other XML documents. XSLT is designed for use as part of XSL, which is a stylesheet language for XML. In addition to XSLT, XSL includes an XML vocabulary for specifying formatting. XSL specifies the styling of an XML document by using XSLT to describe how the document is transformed into another XML document that uses the formatting vocabulary.

APPENDIX C LISTING OF MEDICAID PROVIDER HANDBOOKS

Handbook Title	Update Date
Medicaid Provider General Handbook	
Medicaid Provider General Handbook	January 2004
Medicaid Coverage and Limitations Handbooks	
Advanced Registered Nurse Practitioner	July 2004
Ambulatory Surgical Centers	January 2004
Assistive Care Services and Assisted Living for the Elderly Waiver	July 2001
Birth Center and Licensed Midwife Service	January 2004
Child Health Check-Up (formerly EPSDT)	October 2003
Chiropractic	January 2004
Community Behavioral Health Services	December 2004
County Health Department Certified Match Program	October 2003
County Public Health Unit Clinic Services	October 2003
Dental	January 2004
Developmental Services Waiver	October 2002
Durable Medical Equipment – Medical Supplies	March 2003
Early Intervention Services	October 2003
Federally Qualified Health Centers	October 2003
Freestanding Dialysis Centers	February 1999
Hearing Services	January 2004
Home Health Services	October 2003
Hospice Services	October 2003
Hospital Services	March 2003
Independent Laboratory Services	October 2003
Intermediate Care Facility for the DD (Developmentally Disabled)	March 2003
Medicaid Certified School Match Program	October 2003
Medical Foster Care	October 2003
Mental Health Targeted Case Management	April 2002
Nursing Facility Services	October 2003
Optometry	March 2003
Physician	January 2004
Physician Assistant	January 2004
Podiatry Services	January 2004
Portable X-ray Services	October 2003
Prescribed Pediatric Extended Care Centers	October 2003
Project AIDS Care Waiver Services	July 2003
Registered Nurse First Assistant	January 2004
Rural Health Clinic Services	October 2003
State Mental Health Hospital	July 1997
Therapy Services	October 2003
Visual Services	January 2004
Medicaid Provider Reimbursement Handbooks	
CMS 1500	October 2003
Dental 111	October 2003
Institutional 021	October 2003

Handbook Title	Update Date
Non-Institutional 081	October 2003
Prescribed Drug Services (Contains Coverage and Limitations and Reimbursement)	July 2001
Transportation (Contains Coverage and Limitations and Reimbursement)	July 1997
UB92	April 2004

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APPENDIX D ITEMS IN THE PROCUREMENT LIBRARY

Adobe Reader is required to access most of the documents contained in the library. This software can be downloaded at no cost from the Internet by following this link: Acrobat Reader.

ID#	Procurement Library Item
1	ACS Contract Amendments
2	ACS State Healthcare's Home Page for Florida Medicaid
3	ACS State Healthcare's Web site for Provider Bulletins
4	ACS State Healthcare's Web site for Provider Enrollment Forms
5	ACS State Healthcare's Web site for Provider Fee Schedules
6	ACS State Healthcare's Web site for Provider Handbook Library
7	AHCA Contract Manual
8	AHCA Infrastructure and Wiring Specifications
9	AHCA Security Plan
10	APD for Current Consultant Services Procurement
11	CMS MMIS Certification Guide
12	COOP (Continuity of Operations Plan)
13	Current FA (Fiscal Agent) Contract Papers
14	Current FMMIS System Documentation
15	DMS (Department of Management Services) Leasing Information
16	DSS Documentation
17	Fiscal Agent Organizational Charts
18	Florida Medicaid Statutes
19	Medicaid Organizational Charts
20	Medicaid Program Statistics
21	Medicaid Provider Enrollment Guide
22	Managed Care and MediPass Enrollment Services Contract Papers
23	Report Cards
24	RFP for Current Consultant Services
25	State Buy-in Manual
26	State Holiday Schedule
27	State Medicaid Manual

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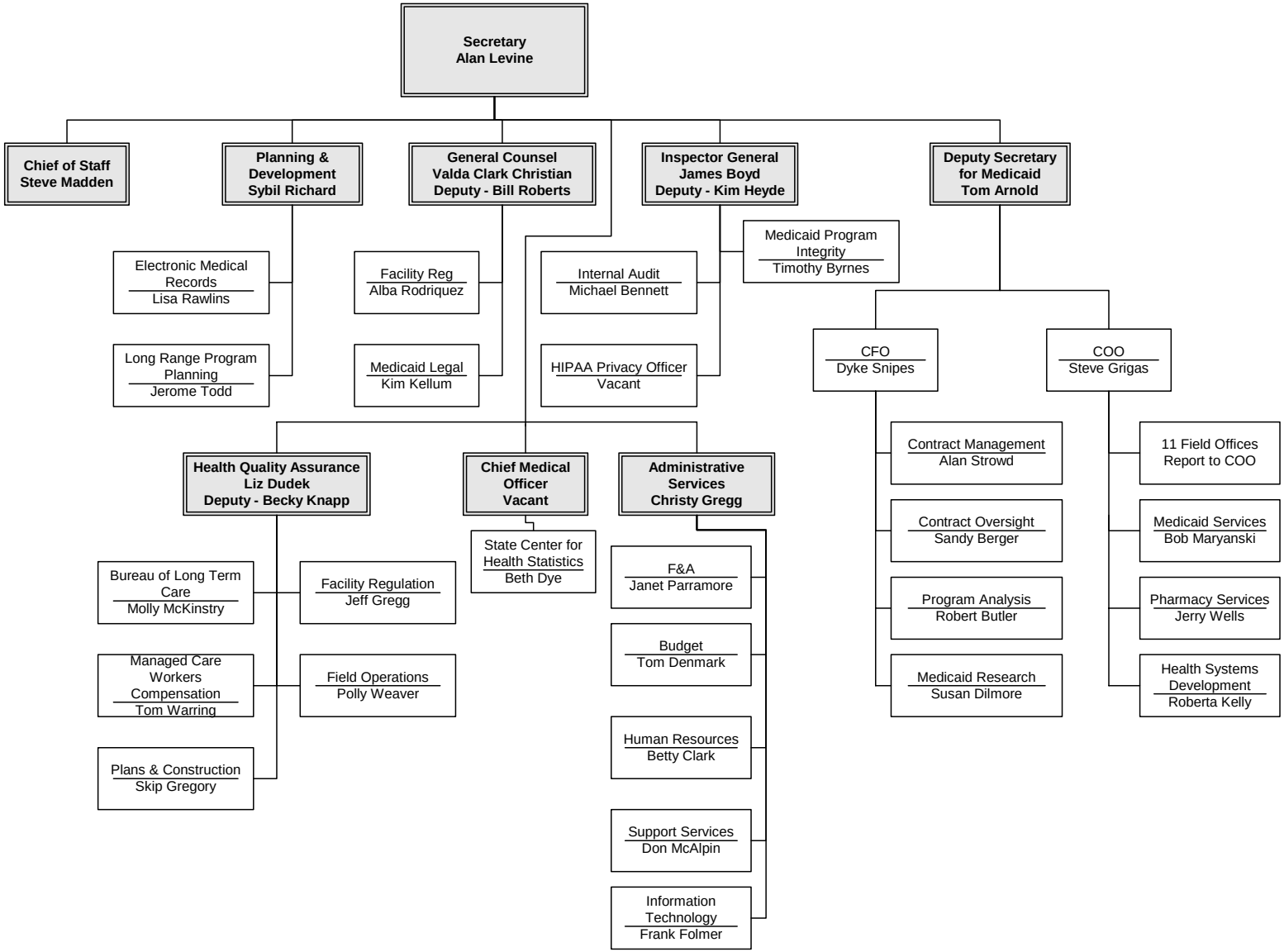
APPENDIX E AGENCY ORGANIZATIONAL CHART



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Medicaid Management Information System/Decision Support System/Fiscal Agent Services Procurement

Request for Proposal

Appendices #2

March 3, 2005

Jeb Bush
Governor

Alan Levine
Secretary
2727 Mahan Drive
Tallahassee, FL 32308

http://ahca.myflorida.com/

APPENDIX F FISCAL AGENT HARDWARE, SOFTWARE, AND COMMUNICATION LINES

EDI DESKTOP/LAPTOP HARDWARE INVENTORY									
No of Units	**Location**	**Mfr.**	**Model**	**Desktop or Laptop**	**Lease or Own**	**Processor**	**MB RAM**	**GB HDD**	**OS**
25	EDI	DELL	Optiplex G1	D	O	P3/ 1 Ghz	256	20	XP PRO
39	EDI	DELL	Optiplex GX260	D	O	P4/ 1.8 Ghz	256	40	XP PRO
107	EDI	DELL	Optiplex GX260	D	O	P4/ 2.4 Ghz	1 GB	40	XP PRO
8	EDI	DELL	Optiplex GX260	D	O	P4/ 1.8 Ghz	1 GB	40	XP PRO
15	EDI	DELL	Optiplex GX260	D	O	P4/ 2 Ghz	1 GB	40	XP PRO
6	EDI	DELL	Latitude C840	L	O	P4/ 2.4 Ghz	1024	40	XP PRO
3	EDI	DELL	Optiplex GX110	D	O	P3/733	128	10	NT4
5	EDI	DELL	Optiplex GX110	D	O	P3/800	128	10	NT4
2	EDI	DELL	Optiplex GX110	D	O	P3/866	128	10	NT4
1	EDI	DELL	Latitude C600	L	O	P3/750	256	20	WIN 2000
1	EDI	DELL	Optiplex GX150	D	O	P3/ 1 Ghz	256	20	NT4
5	EDI	DELL	Optiplex GX150	D	O	P3/ 1 Ghz	256	20	XP PRO
9	EDI	DELL	Optiplex GX150	D	O	P3/933	256	10	WIN 2000
3	EDI	DELL	Optiplex GX150	D	O	P3/ 1 Ghz	256	20	WIN 2000
20	EDI	DELL	Optiplex GX150	D	O	P3/933	128	10	NT 4
17	EDI	DELL	Optiplex GX260	D	O	P4/ 1.8 Ghz	512	40	XP PRO
12	EDI	DELL	Optiplex GX260	D	O	P4/ 2.4 Ghz	512	40	XP PRO
2	EDI	DELL	Latitude C840	L	O	P4/ 2 Ghz	512	40	XP PRO
280	TOTAL								

FLORIDA DESKTOP/LAPTOP HARDWARE INVENTORY									
No of Units	**Location**	**Mfr.**	**Model**	**Desktop or Laptop**	**Lease or Own**	**Processor**	**MB RAM**	**GB HDD**	**OS**
87	FL	DELL	Optiplex G1	D	O	P2/ 350	128	6.4	NT 4.0
10	FL	DELL	Optiplex GX260	D	O	P4/ 2.0 Ghz	512	40	XP PRO
40	FL	DELL	Optiplex GX260	D	O	P4/ 1.8 Ghz		20	XP PRO
5	FL	DELL	Optiplex GX150	D	O	P3/ 1 Ghz	256	20	XP PRO
30	FL	DELL	Latitude C610	L	O	P3/ 1 Ghz	512	20	XP PRO
10	FL	DELL	Optiplex GX260	D	O	P4/ 1.8 Ghz	512	20	XP PRO
11	FL	DELL	Optiplex GX260	D	O	P4/ 1.8 Ghz	512	40	XP PRO
1	FL	DELL	Latitude C610	L	O	P3/ 1 Ghz	512	40	XP PRO
1	FL	DELL	Latitude C640	L	O	P4/ 1.8 Ghz	1024	40	XP PRO
10	FL	DELL	Latitude C840	L	O	P4/ 2Ghz	1024	40	XP PRO
33	FL	DELL	Optiplex GX270	D	O	P4/ 2.4 Ghz	1 GB	40	XP PRO
51	FL	DELL	Optiplex GX270	D	O	P4/ 2.6 Ghz	1 GB	40	XP PRO

FLORIDA DESKTOP/LAPTOP HARDWARE INVENTORY									
No of Units	**Location**	**Mfr.**	**Model**	**Desktop or Laptop**	**Lease or Own**	**Processor**	**MB RAM**	**GB HDD**	**OS**
2	FL	DELL	Latitude D800	L	O	PM/ 1.7 Ghz	1024	40	XP PRO
5	FL	DELL	Optiplex GX150	D	O	P3/933	128	10	WIN 2000
87	FL	DELL	Optiplex GX150	D	O	P3/ 1 Ghz	256	20	WIN 2000
10	FL	DELL	Optiplex GX260	D	O	P4/ 1Ghz	512	40	XP PRO
1	FL	DELL	Latitude C840	L	O	P4/ 2 Ghz	512	40	XP PRO
1	FL	DELL	Optiplex GX270	D	O	P4/ 2.4 Ghz	512	40	XP PRO
2	FL	DELL	Latitude D800	L	O	P4/ 1.7 Ghz	512	40	XP PRO
11	FL	DELL	Optiplex G1	D	O	P2/ 333	128	4.3	NT 4
5	FL	DELL	Optiplex GX150	D	O	P3/ 933	128	10	NT 4
12	FL	DELL	Optiplex GX150	D	O	P3/ 933	256	10	2000
1	FL	DELL	Latitude LCPIA	L	O	P2/ 366	128	6	98
24	FL	DELL	Latitude CPi266	L	O	P/266	64	4.3	NT 4
8	FL	DELL	Optiplex G1	D	O	P/ 350	64	4.3	NT 4
1	FL	DELL	Optiplex G1	D	O	P/ 400	128	6.4	NT 4
2	FL	DELL	Optiplex G1	D	O	P/ 400	64	4.3	NT 4
25	FL	DELL	Optiplex GX110	D	O	P3/ 733	128	10	NT 4
20	FL	DELL	Optiplex GX110	D	O	P3/800	128	10	NT 4
5	FL	DELL	Optiplex GX110	D	O	P3/ 866	128	10	NT 4
1	FL	DELL	Latitude CPxH	L	O	P3/500	128	6.4	98
5	FL	DELL	Latitude C600	L	O	P3/750	128	20	2000
1	FL	DELL	Latitude C600	L	O	P3/850	256	20	2000
3	FL	DELL	Latitude C610	L	O	P3/ 1 Ghz	256	20	2000
1	FL	DELL	Latitude C610	L	O	P3/ 1 Ghz	256	20	XP PRO
1	FL	DELL	Precision 340	D	O	P4/ 1.8 Ghz	512	36	XP PRO
4	FL	DELL	Optiplex GX260	D	O	P4/ 1.8 Ghz	1 GB	40	XP PRO
445	TOTAL								

Desktop / Laptop Software			
Manufacturer	**Application**	**# Licensed**	**Owner**
Borland	C++ Builder 6 Pro	1	FL MED
Legato	2009 Update SVC	1	FL MED
Legato	2902 Update SVC	1	FL MED
Legato	5X9 Phone Support	1	FL MED
Ace	Ace Server ver. 3	1	FL MED
Ace	Ace Server ver. 3	1	FL MED
Adobe	Acrobat 5.0	1	FL MED
Adobe	Acrobat 5.0 Full	5	FL MED
Adobe	acrobat 5.0 Upgrade	1	FL MED
Adobe	Acrobat Pro ver. 6.0	2	FL MED
Winternal	Administrator's Pak 4.0 1-500 EU Maint.	1	FL MED
Winternal	Administrator's Pak 4.0 1-500 Users	1	FL MED

Desktop / Laptop Software			
Manufacturer	**Application**	**# Licensed**	**Owner**
	AutoCAD LT 2002	1	FL MED
	AutoCAD LT 2002 Upgrade	1	FL MED
	CoolEdit 2000	1	FL MED
	DB2 UDB Workgroup Edition License. and 12 month Maintenance	6	FL MED
	Exchange 2000 CAL	1	FL MED
Norton	Ghost	619	FL MED
Norton	Ghost Maintenance	74	FL MED
	HyperStudio ver. 4.0 Lab (5 pack)	1	FL MED
Citrix	Metaframe 1.8	3	FL MED
Citrix	Metaframe XPE 20 user License	1	FL MED
Citrix	Metaframe XPE 20 user Upgrade	1	FL MED
Citrix	Metaframe XPE Starter system w/20 user Lincense	1	FL MED
Citrix	Metaframe XPE Upgrade Starter Sys	1	FL MED
	MicroGOLD WithCLASS 2000 Pro	1	FL MED
Legato	NetWorker Autochanger 1-64 License	1	FL MED
Legato	Networker Client Connections	12	FL MED
	NetWorker for SQL Server	2	FL MED
Legato	NetWorker Server for WIN2K	1	FL MED
Microsoft	Office 2000 Premium	40	FL MED
Microsoft	Office 2000 Pro	118	FL MED
Microsoft	Office 2000 Pro Upgrade	402	FL MED
Microsoft	Office 2003 (XP) Pro	74	FL MED
Microsoft	Office 97 Pro	68	FL MED
Microsoft	Office XP Pro	120	FL MED
Adobe	Pagemaker 7.0	2	FL MED
PowerQuest	Partition Magic 6.0	1	FL MED
PowerQuest	Partition Magic 8.0	25	FL MED
SYMANTEC	PC Anywhere 10.5 Host	9	FL MED
SYMANTEC	PC Anywhere Host and Remote 10.5	8	FL MED
SYMANTEC	PC Anywhere ver. 10	1	FL MED
SYMANTEC	PC Anywhere ver. 8	6	FL MED
Microsoft	Project 2000	1	FL MED
Microsoft	Project 2000 Upgrade	102	FL MED
Microsoft	Project 2002	11	FL MED
Microsoft	Project 2002 Disk Kit	1	FL MED
Microsoft	Project 2003	6	FL MED
Microsoft	Publisher 2000	3	FL MED
Adobe	Publishing Collection	1	FL MED
	RMS Ver. 1.0	1	FL MED
	Rumba ver. 7.1	1	FL MED
Phantom	SAS Additonal Network support	120	FL MED
	SIM2000 Upgrade for the MVS Operating System	1	FL MED
Sybase	SQL Anywhere Studio	1	FL MED

Desktop / Laptop Software			
Manufacturer	**Application**	**# Licensed**	**Owner**
	SQL Anywhere Support Renewal	1	FL MED
Microsoft	SQL CAL Upgrade	13	FL MED
Microsoft	SQL CAL ver. 7.0	2	FL MED
	SQL Server 2000	1	FL MED
Microsoft	SQL Server 2000 CAL	15	FL MED
Microsoft	SQL Server 2000 Standard	1	FL MED
Microsoft	SQL Server Upgrade	2	FL MED
Radius	Steel-Belted Radius After Hours Support	2	FL MED
Radius	Steel-Belted/ EE Maint. Contract	1	FL MED
Legato	StorNet 7X 24 Telephone Support	1	FL MED
SDI	TN3270 Plus	20	FL MED
	Track-It 100 Audits	4	FL MED
	Track-It 4.0 Multi User	1	FL MED
	Track-It Agent	1	FL MED
	Track-It Enterprise Add Users	4	FL MED
	Track-It Enterprise SQL	1	FL MED
	Track-It Priority Support	1	FL MED
	Track-It Receive	1	FL MED
UltraEdit	UltraEdit-32 ver. 10.X 1-9 User License	1	FL MED
UltraEdit	UltraEdit-32 ver. 8.10	1	FL MED
UltraEdit	UltraEdit-32 ver. 9.2	2	FL MED
	Unused Account Ferret 1000 User	1	FL MED
VirtuALL	VirtuALL ToolBox Annual Maintenance	1	FL MED
Microsoft	Visio 2000 Pro Upgrade	3	FL MED
Microsoft	Visio 2002 Pro	24	FL MED
Microsoft	Visio 2003 Pro	1	FL MED
Microsoft	Visio Pro ver. 5	10	FL MED
Microsoft	Visual Basic 6.0 Pro	1	FL MED
Microsoft	Visual SourceSafe 6.0	1	FL MED
Microsoft	Widows 2000 Server	6	FL MED
Microsoft	Windows 2000 CAL	40	FL MED
Microsoft	Windows 2000 Upgrade	582	FL MED
Microsoft	Windows 2003	40	FL MED
Microsoft	Windows NT4 Client License	70	FL MED
Microsoft	Windows NT4 Server	3	FL MED
Microsoft	Windows Server 2003 CAL	156	FL MED
Microsoft	Windows Server 2003 Standard	1	FL MED
Microsoft	Windows XP Pro	1	FL MED
Microsoft	Windows XP Pro Upgrade	404	FL MED
Citrix	Winframe/ Metaframe License	5	FL MED
Citrix	Winframe/ Metaframe License 10U	1	FL MED
Citrix	Winframe/ Metaframe License 20U	1	FL MED
	WinZip	27	FL MED
	WinZip 8.1 Site License	1	FL MED
	WinZip ver. 8	1	FL MED
DB2	Workgroup ED License	1	FL MED

Desktop / Laptop Software			
Manufacturer	**Application**	**# Licensed**	**Owner**
DB2	Wrkgrp ED Internet Access	2	FL MED
DB2	Wrkgrp ED Server License & Maint.	1	FL MED
DB2	Wrkgrp Media Pack ver. 7.2	1	FL MED
DB2	Wrkgrp Universal Database Server	1	FL MED
DB2	Wrkgrp User 1-9 License & Maint.	1	FL MED
	X12 Content and Dataset Loading	1	FL MED
	X12 Dataset Adapter License	1	FL MED
	X12 Usere Interface Rewrite	1	FL MED
Adobe	Acrobat 5.0	3	EDI
Adobe	Acrobat 5.0 Upgrade	1	EDI
Adobe	Acrobat 6.0	1	EDI
Adobe	InDesign 1.5	1	EDI
Adobe	InDesign 2.0	1	EDI
Adobe	InDesign 2.0 Upgrade	1	EDI
Adobe	Pagemaker 7.0	2	EDI
Adobe	Pagemaker 7.0 Upgrade	1	EDI
Adobe	Photoshop 6.0	2	EDI
Adobe	Photoshop 7.0	2	EDI
Adobe	Photoshop 8.0 Upgrade	2	EDI
Borland	C++ Builder 5.0 Pro	2	EDI
Borland	C++ Builder 5.0 Std	1	EDI
Borland	C++ Builder 6.0 Pro	6	EDI
Borland	Jbuilder 5.0 Personal Version	1	EDI
Borland	Jbuilder 7.0 Ent	4	EDI
Borland	Jbuilder 7.0 SE	3	EDI
Borland	Jbuilder 9.0 Ent	6	EDI
Business Objects	Developer Suite 5.0	1	EDI
Business Objects	BO Infoview 5.0	40	EDI
Business Objects	BO Reporter/Explorer 5.0	10	EDI
Business Objects	BO Supervisor 5.0	1	EDI
Computer Associates	AllFusion Erwin Data Modeler 4.1	1	EDI
Cosmi Software	Flow Chart Maker	3	EDI
Excelsior Software	Excelsior Jet 3.0	3	EDI
Gimpel Software	PC-Lint for C/C++	4	EDI
Hummingbird	Exceed Muli-Language 7.1.1	2	EDI
IBM Corp	DB2 UDB Wkgp Server Ed User	1	EDI
IDM	UltraEdit 10.0	82	EDI
IDM	UltraEdit 9.2	44	EDI
Infragistics	Jsuite Developer Gold	2	EDI
IPSwitch	WS_FTP 7.0 Pro	1	EDI
JetBrains, Inc	IntelliJ IDEA 3.0	2	EDI
Meredith Software, Inc	VirtuALL ToolBox 2.4 Site Lic	1	EDI
Microsoft	Office XP Ent	1	EDI
Microsoft	Office XP Pro	135	EDI
Microsoft	Project 2000	27	EDI
Microsoft	Project 2002	40	EDI

Desktop / Laptop Software			
Manufacturer	**Application**	**# Licensed**	**Owner**
Microsoft	Project 2003	1	EDI
Microsoft	SQL Server 2000 Std	3	EDI
Microsoft	SQL Server 2000 CAL	21	EDI
Microsoft	SQL Server 2000 Std w/ 5CAL	1	EDI
Microsoft	Visio 2000 Pro	7	EDI
Microsoft	Visio 2002 Pro	43	EDI
Microsoft	Visio 2003 Pro	1	EDI
Microsoft	Visual SourceSafe 6.0	6	EDI
Microsoft	Windows 2000 CAL	100	EDI
Microsoft	Windows 2000 Pro	1	EDI
Microsoft	Windows 2000 Server CAL	46	EDI
Microsoft	Windows 2000 Server Std	3	EDI
Microsoft	Windows 2003 Server CAL	8	EDI
Microsoft	Windows 2003 Server Std	1	EDI
Microsoft	Windows NT Server 4.0 Open	1	EDI
Microsoft	Windows XP Home	1	EDI
Microsoft	Windows XP Pro	25	EDI
Microsoft	Windows XP Pro Upgrade	9	EDI
NetManage	Rumba Office 7.1	168	EDI
NetObjects	NetObjects Fusion 7.0	2	EDI
PKWare, Inc	PKZip Std 6.0 w/ MS Outlook Intergration	30	EDI
SmartFTP	SmartFTP 1.0	8	EDI
Solutions Consulting	Java Kermit Pro Developer Lic	1	EDI
Solutions Consulting	Java X/Y Modem Pro Developer Lic	1	EDI
Solutions Consulting	Java Zmodem Pro Developer Lic	1	EDI
Solutions Consulting	Windows Desktop Developer Lic	1	EDI
SQLAPI	SQLAPI++ Pro Win32 (with sources)	2	EDI
Symantec	Ghost Corp Edition	52	EDI
Symantec	Ghost Corp Edition Maint., 2yr	10	EDI
Symantec	PC Anywhere 10.0 H/R	3	EDI
Symantec	PC Anywhere 10.5 H/R	8	EDI
Symantec	PC Anywhere 11 H/R	5	EDI
Symantec	ProComm Plus 4.8	1	EDI
Symantec	WinFax 10.0 Pro	30	EDI
Unisyn	Unisyn Automate 5.5 Pro	1	EDI
WinZip	WinZip 8.1	60	EDI

SERVERS				
Model	**Primary Purpose**	**Processor (Ex 4-P3/500)**	**MB RAM**	**Total GB HDD Available**
CCS Encore	AVRS		128MB	8.46GB
Optiplex G1			128	6GB

SERVERS				
Model	**Primary Purpose**	**Processor (Ex 4-P3/500)**	**MB RAM**	**Total GB HDD Available**
PowerEdge 4300	Test TN3270	1-P3/450MHz	512MB	16GB
PowerEdge 4300	DHCP	4/13/1999	1GB	17GB
PowerEdge 1300	Telephony Server	1-P3/450MHz	64MB	8.48GB
Optiplex G1	Wallboard	1-P3/450MHz	256MB	4GB
Optiplex G1	BDC -- RRI	1-P2/350MHz	256MB	6BG
Optiplex G1	PDC -- RRI	1-P2/350MHz	256MB	6BG
Precision 340	IDEXDevelopment	1-P4/1.6GHz	512MB	37GB
PowerEdge 2500	RRI	1-P3/1.4GHz	1GB	50GB
PowerEdge 2650	EDI Comm Machine	1-P4/2GHz	1GB	68GB
PowerEdge 6650	EDI X12 BBS	1-P4/1.9GHz	2GB	546GB
Optiplex G1	PDC	1-P2/400MHz	256MB	8GB
Optiplex G1	DHCP	1-P2/400MHz	256MB	8GB
Optiplex G1	Remote Access	1-P2/400MHz	64MB	3.5GB
Optiplex G1	Remote Access	1-P2/400MHz	64MB	3.5GB
PowerEdge 2500	SMS Server	2-P3/1.13GHz	1GB	170GB
PowerEdge 4600	Exchange		1.5GB	237GB
PowerEdge 4600	XJ Series (EDI)		1GB	168.9GB
PowerEdge 2650	EDI Comm Machine	1-P4/2GHz	1GB	68GB
Power Vault 705N	COLD Import Process			
PowerEdge 4300	XJ Backup		1GB	17GB
PowerEdge 4600	Backup		2GB	85GB
PowerEdge 4600	Server to upgrade CONNIE to OmniTrack	2-P4/3.0GHz	2GB	425.8GB
PowerEdge 4400	EDI IDEX backend	1-P3/1GHz	1GB	101.6GB
PowerEdge 4300	TrackIt	1-P2/350MHz	512MB	17GB
PowerEdge 4300	Decommissioned	1-P2/350MHz	512MB	17GB
PowerEdge 4300	HOD web server	1-P2/350MHz	512MB	17GB
PowerEdge 4300	App Server	1-P2/400MHz	512MB	18GB
PowerEdge 2650	Test PBM Website		4GB	
PowerEdge 4400	Print Server	2-P3/866MHz	2GB	150GB
PowerEdge 4600	XJ Series		2GB	100GB
PowerEdge 4400	File Server	2-P3/800MHz	2GB	150GB
PowerEdge 2650	NDM/FTP Contingency Server	2-P4/2.4GHz	3.68GB	300GB
PowerEdge 4600	XJ Series		1GB	200GB
PowerEdge 2650	RRI	2-P4/2.4GHz	1GB	50GB
Optiplex G150	BDC		128MB	10GB
PowerEdge 2650	RRI	2-P4/2.0GHz	1GB	160GB
PowerEdge 600SC	Telecom DSI		512MB	40GB
PowerEdge 4600	XJ Series		1GB	200GB
PowerEdge 2650	Web Server	2-P4/2.2GHz	2GB	50.8GB
PowerEdge 4600	RRI		2GB	425GB
PowerEdge 4600	EDI File Server	2-P4/1.8GHz	2GB	425GB
Power Edge 4600	Database	2-P4/1.8GHz	2GB	425GB

SERVERS				
Model	**Primary Purpose**	**Processor (Ex 4-P3/500)**	**MB RAM**	**Total GB HDD Available**
PowerEdge 2650	RRI	2-P4/2.2GHz	1GB	16GB
PowerEdge 1550	App Server	1-P3/933MHz	1GB	34 GB
PowerEdge 2500	EDI IDEX Web Server	1-P3/1GHz	1GB	101.6GB
PowerEdge 4400	XJ Series		512MB	26GB
PowerEdge 4400	Decommissioned		512MB	
OptiPlex GX260	App Server	1-P4/1.8GHz	512MB	40GB
PowerEdge 4600	Home Directories		2GB	425GB
PowerEdge 2650	EDI Comm Machine	2-P4/2GHz	1GB	68.3GB
PowerEdge 4600	EDI Host Database	2-P4/1.8GHz	2GB	332GB
PowerEdge 4600	Remote Access	2-P4/1.8GHz	2GB	425GB
PowerEdge 4600	Backup	2-P4/2.0GHz	2GB	50GB
PowerEdge 4600	RRI	2-P4/1.8GHz	2GB	425GB
PowerEdge 2650	Web Server		1GB	50GB
PowerEdge 4600	EDI ACS GCR Web server	2-P4/2.4GHz	2GB	425GB
PowerEdge 4600	XJ Series	1-P4/1.8GHz	2GB	275GB
Precision 340			512MB	40GB
PowerEdge 2650	UAT IDEX	2-P4/2.2GHz	2GB	34GB
OptiPlex GX150	Database		128MB	
PowerEdge 4600	PROD IDEX		2GB	
PowerEdge 2650			2GB	
PowerEdge 2650	RRI		1GB	50GB
PowerEdge 4400	XJ Series		1GB	1250GB
PowerEdge 2650	EDI HIPAA Server	2-P4/2.0GHz	1GB	
Optiplex G1	DHCP		64MB	1.96GB
Optiplex G1	EDI web server		64MB	3GB
PowerEdge 2650	Remote Access	2-P4/2.2GHz	2GB	50.00GB
Optiplex G1	Decommissioned		1GB	4GB
PowerEdge 2650	RRI	2-P4/2.4GHz	1GB	85GB
PowerEdge 2650	EDI HIPAA Server	2-P4/2.0GHz	1GB	105GB
PowerEdge 2650	App Server		2GB	275GB
PowerEdge 600SC	Optical Disk Jukebox w/ Server	1-P4/2.4GHz	512MB	32GB
Precision 420 Destop Unit	PDC	1-P3/800MHz	128MB	8GB
PowerEdge 4600	XJ Series	1-P4/1.8GHz	2GB	425GB
Precision 650	Web Server		256MB	
PowerEdge 2650			1GB	
PowerEdge 2500	RRI	1-P3/1.4GHz	1GB	50GB
PowerEdge 2650	EDI Comm Machine	1-P4/2GHz	1GB	68GB
PowerEdge 600SC	EDI Imaging Server	1-P4/2.4GHz	1GB	70GB
PowerEdge 6300	App Server		2GB	50GB
PowerEdge 4300	File Server	2-P3/450MHz	512MB	44GB
PowerEdge 4300	Print Server		1GB	25GB
IBM E Services P Series				
IBM E Services P Series				

SERVERS				
Model	**Primary Purpose**	**Processor (Ex 4-P3/500)**	**MB RAM**	**Total GB HDD Available**
	CD Writer Server			
	CD Writer Server			
	scan server-XJ			
	scan server-XJ			
	scan server-XJ			
	scan server-RRI			
	scan server-RRI			

SERVER SOFTWARE		
Manufacturer or Provider	**Application or Service**	**# Licensed**
Microsoft	SQL Server 2000 Std Open	1
Microsoft	SQL Server 2000 CAL	50
Microsoft	Windows Server 2000	2
Microsoft	Services for Unix 3.0	8

LAN HARDWARE			
Manufacturer	**Model**	**Device Name**	**Primary Purpose**
	Cisco Catalyst 4506	SHCTLHX04	Switch
	Cisco Catalyst 4503	SHCTLHX05	Switch
	Cisco Catalyst 4506	SHCTLHX02	Switch
Cisco	Catalyst 4506	SHCTLHX04	Switch
Cisco	Catalyst 4503	SHCTLHX05	Switch
Cisco	Catalyst 4506	SHCTLHX02	Switch
Cisco	Catalyst 4506	SHCTLHX03	Switch
Cisco	Catalyst 4507	SHCTLHX13	Switch
Cisco	Cisco 7206	SHCTLHR04	Router
Cisco	Cisco 6513	SHCTLHR03	Router
Cisco	Cisco 2600	SHCTLHR07	Router
Cisco	Cisco Catalyst 6500	SHCTLHX12	Switch
Cisco	Module	SHCTLHR05	Module
Cisco	Module	SHCTLHR06	Module
Cisco	Cisco 7200	SHCTLHR08	Router
Cisco	Catalyst 6500 Series	SHCTLHX01	Switch
Cisco	Catalyst 4506	SHCTLHX06	Switch
Cisco	Catalyst 4506	SHCTLHX07	Switch
Cisco	Catalyst 4506	SHCTLHX08	Switch

LAN HARDWARE			
Manufacturer	**Model**	**Device Name**	**Primary Purpose**
Cisco	Catalyst 4506	SHCTLHX09	Switch
Cisco	Catalyst 4506	SHCTLHX10	Switch
Cisco	Catalyst 4500	SHCTLHX11	Switch
Cisco	Security PIX 525	SHCTLHF02-Prim	Firewall
Cisco	Security PIX 525	SHCTLHF02-Fail	Firewall
Technologic	Interceptor		Firewall/Proxy

WAN Circuits					
Vendor	**Type**	**Speed**	**Protocol**	**Qty**	**Description**
Sprint	Digital Service 1	1.5mbps	PPP	1	Internet connectivity
Sprint	Optical Carrier	155mbps	ATM	1	Connectivity to the State of Florida MAN
AT&T	Digital Service 1	1.5mbps	Frame Relay	2	Connectivity to Mainframe, mid-range, etc. services
MCI	Digital Service 1	1.5mbps	Frame Relay	1	Connectivity to Mainframe, mid-range, etc. services
Qwest	Digital Service 1	1.5mbps	Frame Relay	1	Connectivity to Mainframe, mid-range, etc. services

Main Phone Circuits		
Location	**Circuit ID Number**	**Purpose**
2308 Killearn Ctr Blvd	77 DHZC293062	1st Line Pri T1
2308 Killearn Ctr Blvd	77 DHZC293063	1st Line Pri T1
2308 Killearn Ctr Blvd	77 DHZC293101	1st Line Pri T1
2308 Killearn Ctr Blvd	77 DHZC.293287	KMC Pri
2308 Killearn Ctr Blvd	30HCGS301287	AT&T Pri's via Sprint
2308 Killearn Ctr Blvd	30HCGS301393	AT&T Pri's via Sprint
2308 Killearn Ctr Blvd	30HCGS301604	AT&T Pri's via Sprint
2308 Killearn Ctr Blvd	30.HCGS.413383	AT&T Pri's via Sprint

UPS						
Location	**Location of Generator**	**Powers: Data Center or Bldg**	**Fuel Type**	**Location UPS**	**Powers: Data Center or Bldg**	**List Areas Supported: - Data Center - Help Desk - All Desktops - Phone System - Security System**
2308 Killearn Ctr Blvd	Northwest side of Building A	Building Only.	Diesel	130 KVA ups that supports Building A,B,&C is in the Computer/Server room in Building C.	Data center and Buildings (3)	All of the above.
2308 Killearn Ctr Blvd	Southside between Building B&C	Building and Data Center	Diesel	130 KVA ups that supports Building A,B,&C is in the Computer/Server room in Building C.	Data center and Buildings (3)	All of the above.
2308 Killearn Ctr Blvd	Southeast side of Building E	Building and Data Center	Diesel	40 KVA UPS that supports Building E IS IN THE Host Room on the first floor.	Host Room and Building.	All of the above.
2308 Killearn Ctr Blvd	North side of Building	Building and Data Center	Diesel	120 KVA located in the Data Center	Data center and Buildings	All of the above.

Backup Devices						
Manufacturer	**Model**	**Device Name**	**Leased or Owned (L or O)**	**# Tapes per Month**	**Stored Off Site (Y or N)**	**Platforms Attached**
StorageTek	L40	"L40"	O	70	Y	NT Server
StorageTek	Timberwolf 9730	"Timberwolf"	O	60	Y	NT Server
Dell	Powervault 110T	Powervault	O	12	N	NT Server

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APPENDIX G STATE HARDWARE AND SOFTWARE

Definitions:

- Headquarters: Medicaid Headquarters is located at 2727 Mahan Drive, Ft. Knox Building 3, 3rd floor, Tallahassee, FL 32308
- Backbone: Cat5 and Gigabit Cabling, Multi mode Fiber Optics or combination of both Ethernet and Gigabit switches.
- Local Area Network (LAN): Backbone and Network Servers
- Wide Area Network (WAN): Connection between two LANs.
- Routed Transport Protocol (RTS): Wide Area Network provided by the Division of Communication.
- Metropolitan Area Network (MAN): A city wide fiber optics network
- Sprint Gigabit MAN: 100Mb connection

This appendix lists the equipment that needs to be purchased for the state, which includes personal computers, printers, network switches, servers, backup devices, and other miscellaneous equipment. Final specifications and expenditures will be released at the time of purchase.

All personal computers, printers, servers, network equipment, and other peripheral equipment supplied by the contractor and located in state offices will become the property of the State of Florida upon delivery and setup.

Personal Computers – Current Standards:

The current Agency standard for desktop hardware configuration consists of the following items:
- Intel P4 3.2ghz / 800Mhz Front Side Bus / 1mb cache;
- 40gb IDE 7200 speed hard drive;
- 3.5 inch HD floppy drive;
- Intel ATX motherboard;
- 1 - 512mb DDR Non-ecc SDRAM 333mhz;
- Integrated Video;
- Integrated Intel Gigabit (10/100/1000) NIC;
- 19” .26 pitch monitor;
- Microsoft style mouse; and
- Microsoft keyboard.

The desktop operating system is Windows 2000. The desktops are loaded with the following:
- Microsoft Office 2000 (Word, Excel, PowerPoint, Access, Publisher);
- Microsoft Outlook 2000;
- McAfee Virus Scan v 4.5.1 SP 1; and
- Microsoft Internet Explorer v6.0 SP2 (uses the Agency’s proxy server for all protocols).

Network Printers – Current Standards:

Current purchasing standard for high-speed network printers are as follows:
- HP Laserjet 8150N - (Duplexing); and

- HP Laserjet 4650DN (Color) - (Duplexing).

LCD Projector – Current Standards:

Viewsonic PJ750 LCD Projector

The present personal computer, network printer, and LCD projector standards are subject to upgrades prior to purchase. The vendor and equipment specifications must be approved by the Agency (AHCA IT) prior to purchase.

Scanners – Current Standards:

HP Scanjet 8250 15 page/minute automatic document feeder. Imaging and OCR software is included.

Network Diagram/Description:

Diagrams of the Headquarters and Area Offices Network Configuration and the AHCA State Network are included in this appendix.

The Medicaid Program serves the State of Florida from its Headquarters' offices (including three off-site locations) plus eleven (11) area offices and two (2) satellite offices. Each Area office has a Local Area Network (LAN) connected to the Wide Area Network (WAN) provided by the State's Routed Transport Service Network (RTS). Each Satellite office Backbone connects to its prospective Area office via the RTS network.

MIS SOFTWARE STANDARDS

The software listed below represents current versions as of January, 2002, however, all software is upgraded to the latest version as it becomes available.

The following software is licensed through Microsoft Select Agreement (purchased through MIS only) for all employees and available on the Agency's servers:

PRODUCT	VERSION	DESCRIPTION
Microsoft Word 2000	9.0.6926 SP-3	Word Processor
Excel 2000	9.0.6926 SP-3	Spreadsheet
PowerPoint 2000	9.0.6620 SP-3	Presentation, Org. Charts, Flowcharts
Access 2000	9.0.6926 SP-3	Database software, SQL querying tool
Outlook 2000	9.0.0.6627 SP-3	Mail Client (send/receive mail) / Calendar
Windows 2000	5.00.2195	Operating System
McAfee Virus	4.5.1 SP1	Virus scan and clean software
Internet Explorer	6.0.2800.1106	Intranet/Internet Web Browser
MS Power Point or MS Word 2000	9.0.6620 SP-3	Org. Chart Software

The following software has been proven successful on Agency standard equipment (is purchased on a per license basis):

PRODUCT	VERSION	DESCRIPTION
Adobe Acrobat Reader	5.0	Views web pages (No license fee required)
Informix32 w/OLEDB Provider	2.30	Informix database connectivity software
Law Desk	2.7	Administrative Codes and Florida Statutes
West Law	3.5	Florida Cases/Citations
QPC WinQVT	4.05	Telnet 3270 (FMMIS, CMS/BEST, FLORIDA, etc.)
Q+E Data Explorer	3.0	SQL database querying/reporting tool
Cognos Impromtu	6.0	Database querying/reporting tool
Net Manage Chameleon Host Link 97	8.0	3270 Mainframe Emulation (Supplied by vendor)

Florida Medicaid DSS Hardware and Software Requirements

The hardware and software for the Medicaid Decision Support System (DSS) are currently on site and integrated with the Agency's network configuration although the contractor, ACS, has the responsibility for all maintenance and upgrades. Similar hardware and software solutions will be needed to replace the Medicaid DSS.

The following software has been proven successful on Agency standard equipment (is purchased and licensed via the DSS contract per user and per concurrent user):

PRODUCT	VERSION	DESCRIPTION
QueryPath	4.2	ACS/DSS proprietary Ad Hoc Query and Reporting Tool available via Web Browser.
Business Objects	6.5	Ad Hoc Query and Reporting tool
SPSS	12.0	Statistical Software suite loaded on Server and accessible via Citrix for 8 concurrent users.
ArcView	8.3	Geographic Information System (GIS) application loaded on Server and accessible via Citrix
OmniAlert	2.0	ACS Fraud and Abuse Detection tool replaces mainframe SURS
HealthSpotlight		ACS enhanced Fraud and Abuse Detection tool via Web Browser to identify patterns of abuse
DxCG RiskSmart	1.2.3	Web-based tool using DxCG (Diagnostic Cost Group and Rx-Group predictive models for clinical analysis.
Citrix Metaframe		Provides remote access to servers.
EIS (Executive Information System)		Proprietary and customized reporting for Medicaid Management team via Web Browser.

Other software includes Oracle, Teleran, Veritas, BEA Weblogic, etc. used for the operations of the Medicaid DSS.

Hardware necessary for the operation of the current DSS includes the following:

- Sun Fire 6800 48GB Database Server;
- StorEdge 6320;
- Sun Fire V440/ Dev /QP/HS;
- Sun Fire V440/ Dev / Test ;
- Sun Blade Workstations (2);
- Sun Fire V880 4*1.2/QP;
- Sun Fire V440 4* 1.062 /OA;
- Sun Fire V440 2*1.062 /HS & EIS;
- SunS StorEdte L100 /Backup/Rec;
- Sun Rack;
- Dell 2650 /OA App Server;
- Dell 2650 /Misc App;
- Dell 6650 /DxCG RiskSmart;
- Dell 6650 / Citrix; and
- Dell Rack.

Contractor Responsibilities – Purchase and Delivery of Personal Computers, Printers, Networking Hardware and Other Miscellaneous Equipment/Software:

General Requirements:

The contractor will be expected to perform the following tasks:

- Ordering all equipment as approved by the Agency;
- Delivery of the hardware to the designated Tallahassee, area office or satellite office location; and
- Software purchases or licensing required for the DSS, user/MMIS interface, or other operations e.g. terminal emulator software.

Bulk hardware purchases of personal computers will be coordinated with AHCA's Information Technology staff and will occur no more than four times within the term of the initial contract at no less than six-month intervals.

The actual cost for the equipment included in this section will be a pass-through to the Agency as indicated in Subsection 30.27.3.

Personal Computers:

A total of 906 new personal computers for Medicaid staff will be purchased and installed during the initial 5-year contract period. The purchase and installation period will commence when the current desktop machines approach the end of their warranty period (4 years*). A staggered replacement of personal computers will start in FY 2009-2010. The number of PCs by location may be found in this appendix.

*New PC installation for all Medicaid employees is expected during FY 2005-2006 under the current contract.

Printers:

High Speed Duplexing Laser Printers will be purchased by the winning bidder and delivered to each of seven (7) Medicaid bureaus located in Tallahassee, eleven (11) area offices, and two (2) satellite area offices located throughout the state.

LCD Projector:

LCD Projectors will be purchased by the winning bidder and delivered to the DSS training room, to each of seven (7) Medicaid bureaus located in Tallahassee, eleven (11) area offices, and two (2) satellite area offices located throughout the state.

Scanners:

Scanners will be purchased by the winning bidder and delivered to each of seven (7) Medicaid bureaus located in Tallahassee, eleven (11) area offices, and two (2) satellite area offices located throughout the state.

A list of area and satellite offices and their location is included in this appendix.

Networking and Miscellaneous Equipment:

The following networking and miscellaneous equipment will be delivered to headquarters or the area offices as determined by AHCA IT:

- Sixty-seven (67) servers including yearly capacity upgrades;
- Sixteen (16) Switches;
- Nine (9) routers including yearly capacity upgrades; and
- Tape backup, UPS, cabling, climate control and other miscellaneous equipment.

Medicaid Program Analysis Server

In addition to the equipment described earlier in the appendix, the contractor will procure a server for Medicaid Program Analysis based on the following specifications at an estimated cost of $80,000 to $100,000:

- Quad Processor 6.0 GHz Pentium 4 tower system (or current Intel processor);
- 32 GB of RAM;
- 2 Terabytes SCSI Raid 5 (15K or better rotational speed);
- Dual 1 GB Ethernet NIC (Copper Wire) – Compatible with Agency Network Cabling System and installed OS;
- Windows 2003 Enterprise Server (or later Microsoft OS);
- MS SQL Server 2005 (or later) Enterprise Edition with 25 or more user licenses;
- 17” or better flat screen LCD monitor;
- Video system compatible with installed operating system and monitor;
- High Capacity Tape (SDLT or later) or Optical Backup System;
- DVD-RW drive;
- 16 port gigabyte Ethernet switch;
- UPS capable of automatic system shutdown with installed OS and 15 minutes operating time in the event power failure;
- 3490E autoloader tape drive; and
- Appropriate cabling.

The final specifications will be validated with the Agency (AHCA IT) prior to purchase. The contractor must provide hardware and software support for the server at no additional cost to the Agency for the period of the fiscal agent contract.

AHCA IT Responsibilities – Imaging, Installation, and Setup of Personal Computers:

Upon awarding the contract, AHCA Information Technology will develop an installation plan to cover all Tallahassee locations, and all area and satellite offices.

Personal Computers:

AHCA Information Technology will be responsible for installation and setup of all personal computers in the Tallahassee headquarters facility, three (3) off-site locations, eleven (11) area offices and two (2) satellite offices throughout the state. Installation and setup will include:

- Receipt and staging of all equipment;
- Imaging the hard drive;
- Installation of all software licensed to the Agency. This will also include desktop network and e-mail configuration. (A list of software licensed to the Agency is included in this appendix);
- Transferring the users local files to the new computer's hard drive; and
- A setup checklist, requiring approval by the user, will be used to insure complete setup.

Printers:

The High Speed Laser Printers and scanners purchased under this contract will be connected to the Agency's network by AHCA IT support staff.

Headquarter Requirements:

AHCA IT will provide a sufficient number of ports to cover all Medicaid users, printers, and other networking devices. AHCA IT support staff will connect all networking equipment purchased for the Agency during the initial contract.

Area and Satellite Offices:

With the implementation of recently installed networking equipment, there are more than enough ports to meet the capacity needed, as well as room for future expansion. AHCA IT support staff will connect all networking equipment purchased for the Agency during the initial contract.

Location of Florida Medicaid Area and Satellite Offices

Area & Satellite Offices	LOCATION
Area Office 01	160 Governmental Center Room 510 Pensacola, Fl 32502 (T1 Line)
Area Office 02a Satellite	651-K W. 14th St. Panama City, Florida 32401 (T1 Line)
Area Office 02b	2002 Old St. Augustine Rd. Bldg. D, Suite 194 Tallahassee, Fl 32303 (10mb)
Area Office 03a	14101 N.W. Hwy. 441, Suite 600 Alachua, Florida 32615-5669 (T1 Line)
Area Office 03b Satellite	2441 W. Silver Springs Blvd. Ocala, Florida 34475 (T1 Line)
Area Office 04	Duval Regional Service Center 921 N. Davis St. Building A, Suite 160 Jacksonville, Florida 32209-6806 (T1 Line)
Area Office 05	525 Mirror Lake Drive N., Suite 510 St. Petersburg, Florida 33701 (T1 Line)
Area Office 06	6800 N. Dale Mabry Hwy., Suite 220 Tampa, Florida 33614 (T1 Line)
Area Office 07	400 W. Robinson St., Hurston South Tower, Suite S309 Orlando, Florida 32801 (T1 Line)
Area Office 08	Regional Services Center 2295 Victoria Ave., Room 309 Ft. Myers, Florida 33901 (T1 Line)
Area Office 09	1710 E. Tiffany Drive West Palm Beach, Florida 33407 (T1 Line)
Area Office 10	1400 W. Commercial Blvd., Suite 110 Ft. Lauderdale, FL 33309 (T1 Line)
Area Office 11	8355 N.W. 53rd St. Koger Center 2nd Floor Manchester Bldg. Miami, Florida 33166 (T1 Line)

Area & Satellite Offices	LOCATION
Medicaid Program Integrity	8350 NW 52 Terrace Room 410 Miami, FL 33166
Program Analysis Audit	921 N. Davis Street Building A, Suite 160 Jacksonville, FL 32209
Program Analysis Audit	525 Mirror Lake Drive Sebring Building, 3rd Floor St. Petersburg, FL 33701

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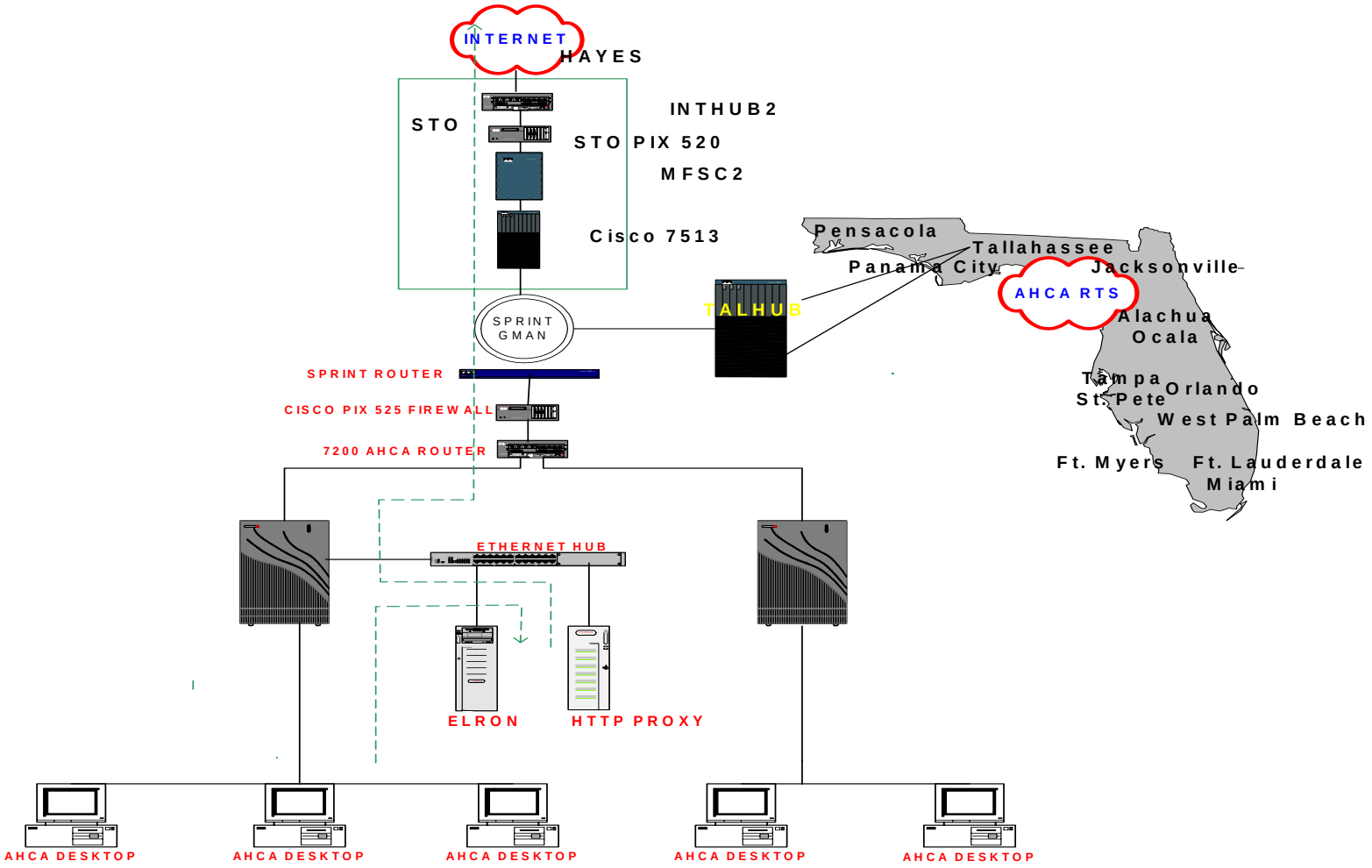
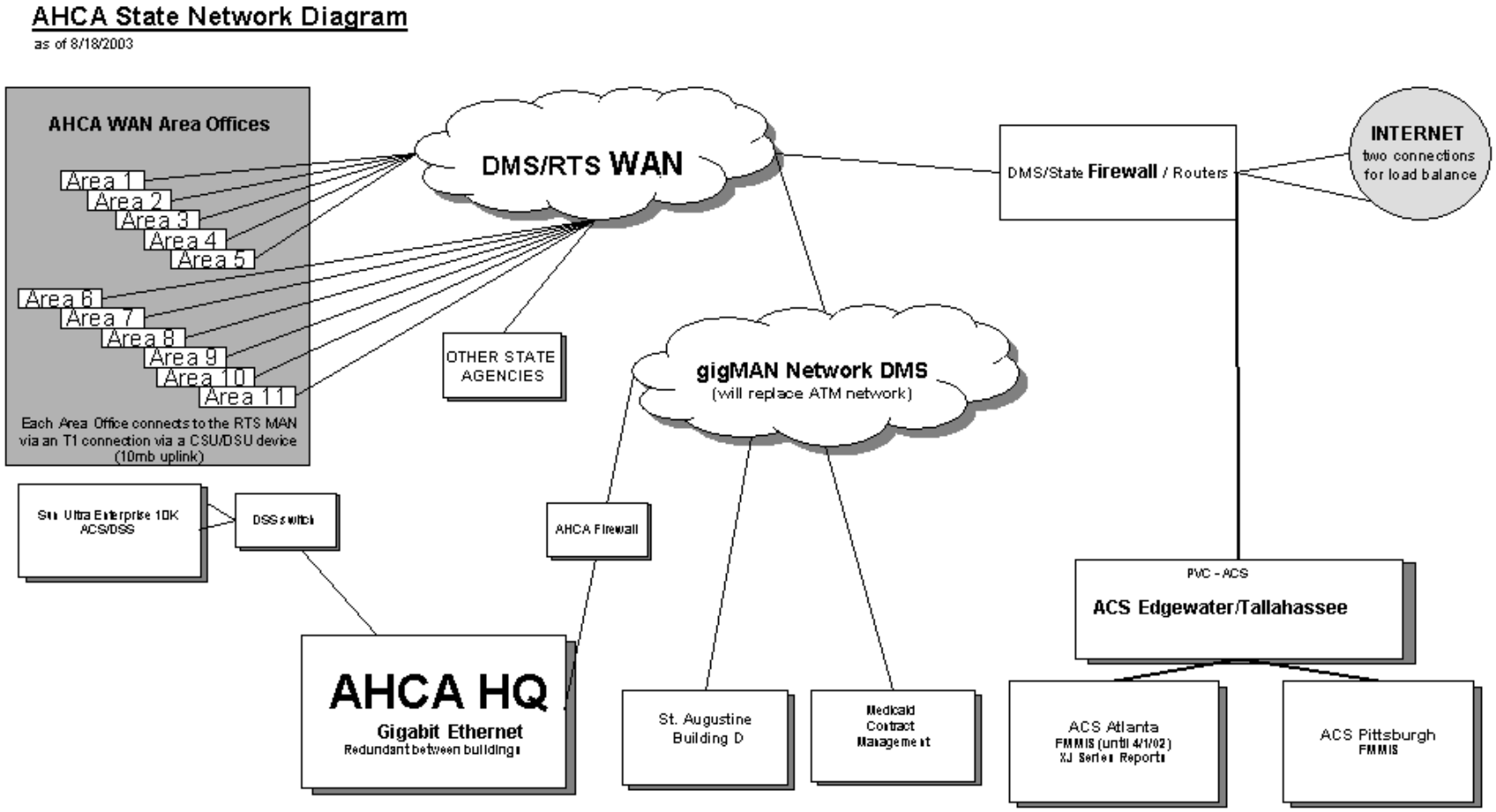
Headquarters and Area Offices Network Configuration




AHCA State Network Diagram
as of 8/18/2003
AHCA WAN Area Offices
Area 1
Area 2
Area 3
Area 4
Area 5
Area 6
Area 7
Area 8
Area 9
Area 10
Area 11
Each Area Office connects to the RTS MAN via an T1 connection via a CSU/DSU device (10mb uplink)
DMS/RTS WAN
OTHER STATE AGENCIES
gigMAN Network DMS
(will replace ATM network)
DMS/State Firewall / Routers
INTERNET
two connections for load balance
Sun Ultra Enterprise 10K ACS/DSS
DSS switch
AHCA Firewall
AHCA HQ
Gigabit Ethernet
Redundant between buildings
St. Augustine Building D
Medicaid Contract Management
PVC - ACS
ACS Edgewater/Tallahassee
ACS Atlanta
FMMIS (until 4/1/02)
XJ Series Reports
ACS Pittsburgh
FMMIS

APPENDIX H FISCAL AGENT WORKLOAD STATISTICS

The workload statistics for the FMMIS are listed below:

FLORIDA FAS STATISTICS		
Element/Metric	**Value Reported**	**What To Report**
Number of lines of COBOL	3 Million	Production FMMIS COBOL programs; lines of code
Number of application programs	Production: 2,379 AdHoc: 2,293	Production FMMIS COBOL programs
Number of checks mailed weekly	Range: 1,252-2,250 Average: 1,590	Number of paper checks mailed per week for past 52 weeks
Number of EFT payments weekly	Range: 14,954-20,386 Average: 17,634	Number of EFT payments per week for past 52 weeks
Number of remittances mailed weekly	Range: 19,072-31,695 Average: 21,156 *Excluding week 17	Number of paper RVs mailed per week for past 52 weeks
Number of remittances by EFT weekly	Includes all listed ERVs Range: 3,793-12,210 Average: 11,343	Number of electronic remittances posted per week for the past 52 weeks. Include ERVs, tape RVs; and, 835s & 820s
Number of PA requests received weekly	Range: 1,954-40,776 Average: 18,621	Number of PA requests received weekly for past 52 weeks; include pharmacy as well as non-pharmacy requests
Number of phone lines		
OC3	1	
Dedicated T1 Lines	8 voice circuits, 4 data (201 lines)	Number of lines; include voice & data circuits dedicated to Florida Medicaid
Frame Relay T1's with Permanent Virtual Circuits (PVC's)	3	
Dedicated 56KB Lines	0	Number of lines; include voice & data circuits dedicated to Florida Medicaid
Switched 14.4KB Lines	0	Number of lines; include voice & data circuits dedicated to Florida Medicaid
Amount of images on magnetic storage		Total number of imaged documents stored on CD. Include paper & electronic pseudo-images
Claim Images (ACS)	58,584,174	
Claim Images (Unisys)	27,073,985	
Provider Document Images	213,168	
EMC Claim Pseudo-image data records	409,765,592	
COLD Reports	460,202	

Element/Metric	Value Reported	What To Report
Number of optical disks with images		Number of CD media containing imaged documents, not including backups
Claims (ACS)	1,804	
Claims (Unisys)	4,000	
Provider Document Images	143	
COLD Reports (backups)	916	
Number of data entry shifts	1	Current number of data entry shifts
Number of data entry FTEs	18	
Day Shift	18	Current number of full time data entry staff on day shift; exclude resolution & exam entry staff
Evening Shift	0	Current number of full time data entry staff on evening shift; exclude resolution & exam entry staff
Mail Room average daily receipts	Range: 4,050-64,000 Average: 25,502	Number of mail pieces received per day by the Mail Room for past 30 days
Mail Room highest week day receipts	Range: 24,700-60,650 Average: 47,099	The high daily Mail Room receipts per week for the past 52 weeks
Number of claims & claims-related documents keyed each week	Range: 61,211-141,918 Average: 116,842	Number of claims and claim-related documents (attachments) scanned per week for past 52 weeks. Include OCR and exam entry
Volume of Medicaid ID cards mailed monthly	Range: 48,487-87,275 Average: 67,473	Number Medicaid ID cards mailed per month for past 60 months
Other recipeint mailings for the current year	Range: 1,992,428-5,598,590 Average: 3,785,536	The total number of recipient mailing pieces during per state fiscal year for the past 5 years; exclude ID card mailings
Volume of prior authorization letters to providers / recipients monthly	Range: 4,656-73,814 Average: 27,556	Number of provider and recipient PA letters mailed per month for past 60 months; include pharmacy and non-pharmacy PAs
Volume of drug exception requests weekly	0	Number of DERs received per week for past 52 weeks
Monthly volume of county billings	Range: 51,747-77,568 Average: 57,175	Number of county billings generated by the County Billing Subsystem per month over the past 60 months
Manual updates by the fiscal agent for the year	Range: 80,000-134,692 Average: 112,545	The total number of file maintenance updates keyed per state fiscal year for the past 5 years
Eligibility form 2014s	Range: 14,230-16,646 Average: 14,849	The total number of 2014 updates received per state fiscal year for the past 5 years
Drug Exception Requests	0	[see above]

Element/Metric	Value Reported	What To Report
Specified Low Income Medicare Beneficiaries (SLMB)	Range: 608-11,958 Average: 2978	Number of SLMB transactions applied per month to the Recipient Eligibility File for the past 60 months
Number of publications produced	8/month	The current number of regularly produced publications
System files/tapes	2,000	Estimate of the number of tape volumes that would be required to contain the FMMIS application code, JCL and all production data files (current generations only)
Paper claims; Optical disk	ACS: 1,804; Unisys: 4,000	Number of archived (backup) image CDs
Paper files (enrollment files, banking files and canceled checks, etc)	Banking: 1,648 boxes; FL Med claims & misc: 21,100 boxes; Unisys claims 4,500 boxes; Enrollment: 2,000 boxes	Estimate of the number of boxes of all archived hard copy files, such as provider enrollment files, banking files, cancelled checks, etc.

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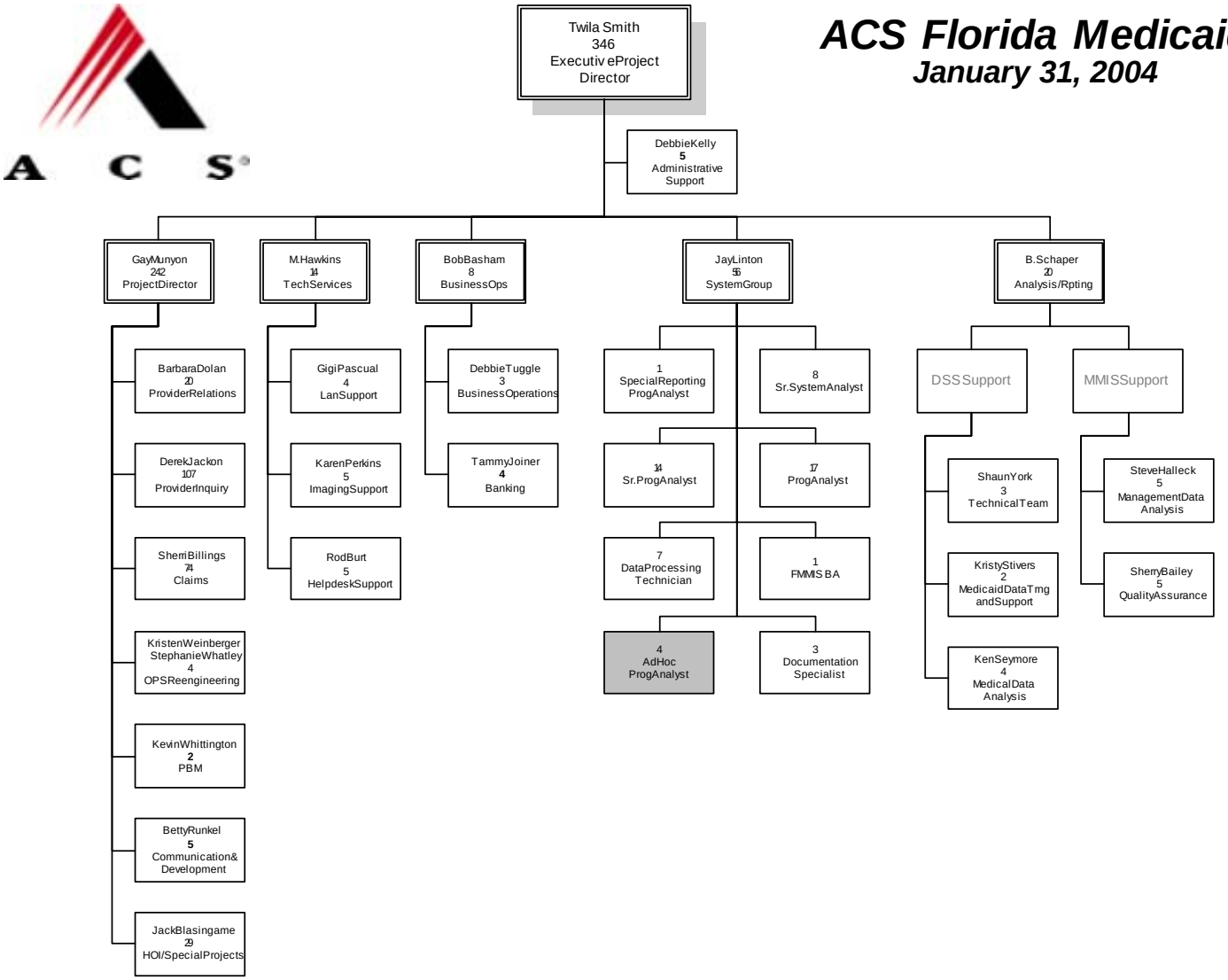
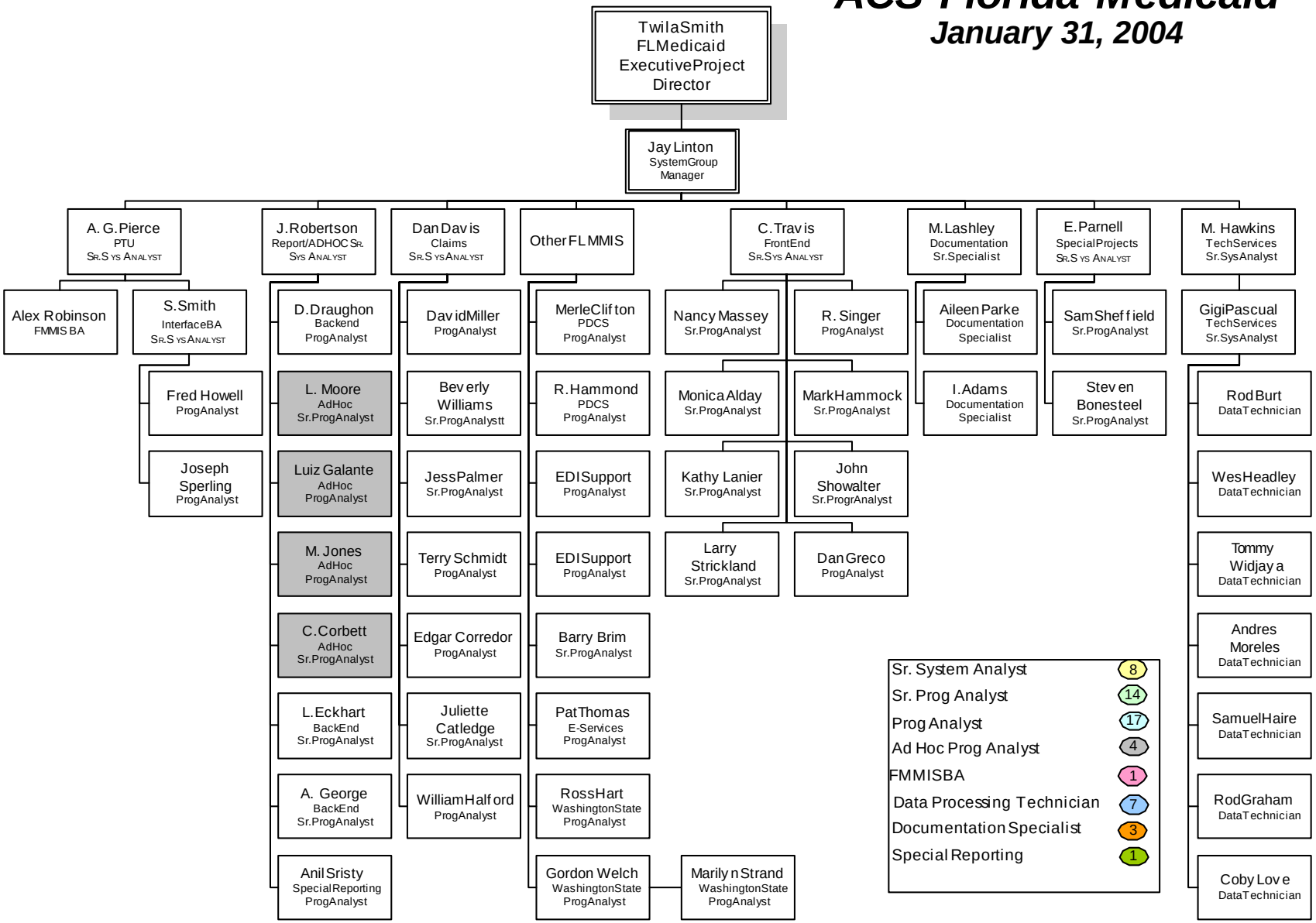
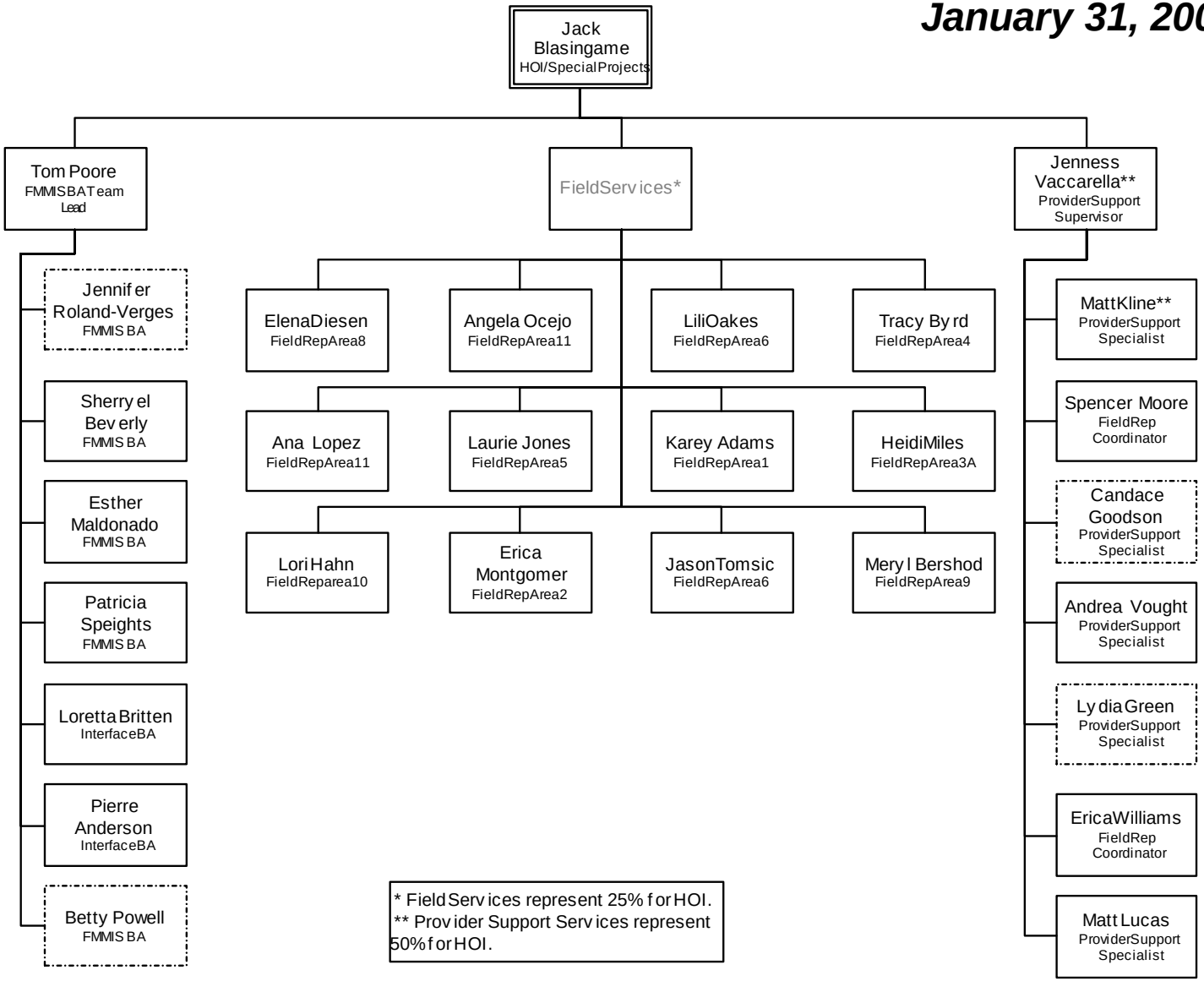
APPENDIX I FISCAL AGENT ORGANIZATIONAL CHARTS



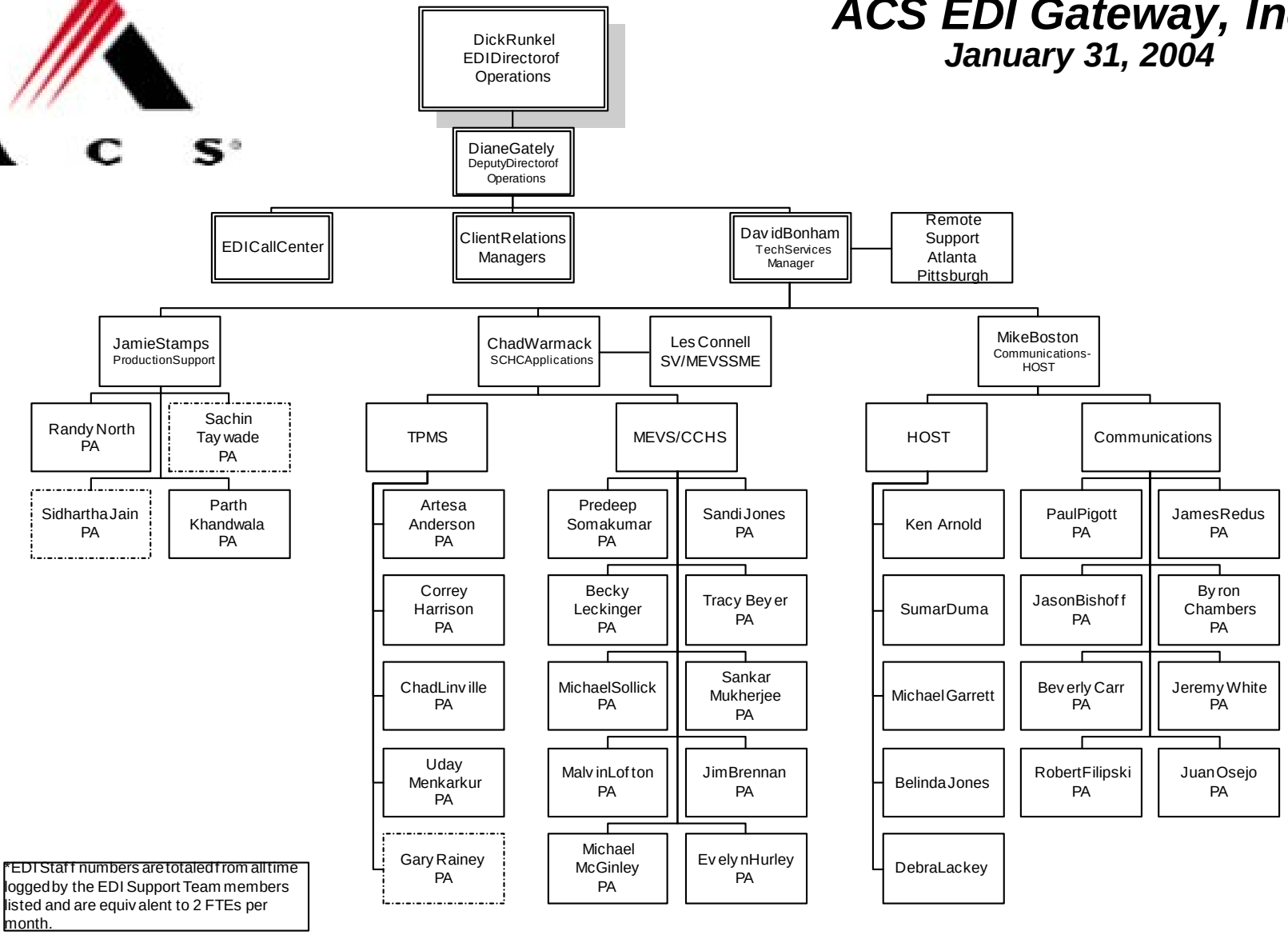
ACS Florida Medicaid
January 31, 2004



ACS Florida Medicaid
January 31, 2004



ACS EDI Gateway, Inc.
January 31, 2004



*EDI Staff numbers are totaled from all time logged by the EDI Support Team members listed and are equivalent to 2 FTEs per month.

Medicaid Management Information System/Decision Support System/Fiscal Agent Services Procurement

Request for Proposal

Appendices #3

March 3, 2005

Jeb Bush
Governor

Alan Levine
Secretary
2727 Mahan Drive
Tallahassee, FL 32308

http://ahca.myflorida.com/

APPENDIX J PROPRIETARY AND LICENSED SOFTWARE OWNED BY THE INCUMBENT FISCAL AGENT

PROPRIETARY AND LICENSED SOFTWARE OWNED BY THE INCUMBENT FISCAL AGENT			
Quantity	**Vendor**	**Product**	**Description**
Unlimited	eServices	XJ	Imaging system
Unlimited	ACS	Omnitrack	Client Access License Resource Mgmt
Unlimited	ACS-EDI	CAPS	x12 transactions tracking system
Unlimited	ACS	Consultrack	Time-Logging
Unlimited	Recognition Research	RRI	Claims Processing
220	IBM	Host on Demand	Mainframe client application
9	Peregrine	ServiceCenter	Helpdesk, Inventory & Purchasing Tracking
5330	IPSwitch	ScriptLogic	Domain automation
125	Spanlink	FastClient Access License	Telephony Client Access Licensel mgmt app
25	AVAYA	CMS Supervisor	Telephony Client Access Licensel mgmt/mor
5	CD Software Solutions	Image Depot Express	Provided to the banking dept. by an outside
Unlimited	Network Associates	McAfee Enterprise	Antivirus app
	Nortel	Extranet	VPN client
500	Winternals	ERD Commander	PC maintenance
7	Adobe	Adobe Acrobat 5.0	File viewer
2	Adobe	Adobe Acrobat 6.0	File viewer
2	Adobe	Adobe Pagemaker 7.0	Publication
1	Autodesk	Auto Cad LT 2002	Drafting
1	Autodesk	Autodesk AutoCAD LT 2000	Drafting
1	Autodesk	AutoCAD LT 2002 Upgrade	Drafting
I	Citris Systems	Citrix Metaframe XPE 20 user license pack	Remote Access
1	Citris Systems	Citrix Metaframe XPE 20 user upgrade pack	Remote Access
1	Citris Systems	Citrix Metaframe XPE Starter System w/sub(20usr)	Remote Access
1	Citris Systems	Citrix Metaframe XPE Upgrade Starter System	Remote Access
3	Syntrillium	Cooledit 2000	Audio editor
8	IBM	DB2 Workgroup Edition License	Database
1	IBM	DB2 Wrkgrp ED Internet Access 1	Database

PROPRIETARY AND LICENSED SOFTWARE OWNED BY THE INCUMBENT FISCAL AGENT			
Quantity	**Vendor**	**Product**	**Description**
1	IBM	DB2 Wrkgrp Universal Database Server CD	Database
2	Sewell Development	FastLynx 3.3 Premium Package	PC data migration
1	Software Spectrum	Ghost for License Compliance (500copies)	Backup, disaster recovery
2	Software Spectrum	Ghost Maintenance	TechniClient Access License Support
27	IBM	Host Access Client Package NMS	TN3270
5	Sunburst	HyperStudio 4.0	Training production
1	@stake	LC4 (LOphtCrack)	Network Administration
11	SANZ	Legato Networker Client Connections for Windows/UNIX	Backup, disaster recovery
1	SANZ	Legato Networker Module for Microsoft	Backup, disaster recovery
2	Microsoft	MS Exchange 5.5 Enterprise	Email
40	Microsoft	MS Office 2000 Premium	Office automation
340	Microsoft	MS Office XP Pro Upgrade	Office automation
152	Microsoft	MS Office XP Professional	Software training
2	Microsoft	MS Outlook Training	Office automation
24	Microsoft	MS Project 2000	Office automation
9	Microsoft	MS Project 2002	Office automation
43	Microsoft	MS Project 2002 Upgrade	Office automation
4	Microsoft	MS Project 2003	Office automation
7	Microsoft	MS SQL 2002 Client Access License Upgrade	Database
2	Microsoft	MS SQL Server 2002 Upgrade	Database
1	Microsoft	MS Visio 2002 Pro Upgrade	Drafting
14	Microsoft	MS Visio 2002 professional	Drafting
1	Microsoft	MS Visio 2003 Pro	Drafting
1	Microsoft	MS Visio Pro 2000 Upgrade	Drafting
70	Microsoft	MS Windows 2000 Client Access License	Operating System
20	Microsoft	MS Windows 2000 Client Access License Plus SA	Operating System
537	Microsoft	MS Windows 2000 Client Access License Upgrade	Operating System
3	Microsoft	MS Windows 2000 Pro	Operating System
85	Microsoft	MS Windows 2003 Client Access License	Operating System
4	Microsoft	MS Windows NT Server v 4.0	Operating System

PROPRIETARY AND LICENSED SOFTWARE OWNED BY THE INCUMBENT FISCAL AGENT			
Quantity	**Vendor**	**Product**	**Description**
1	Microsoft	MS Windows Server 2000	Operating System
2	Microsoft	MS Windows Server 2003 WNT Client Access License	Operating System
2	Microsoft	MS Windows Server Upgrade	Operating System
50	Microsoft	MS Windows XP - Professional [5.1.2600]	Operating System
3	Microsoft	MS Windows XP Pro	Operating System
54	Microsoft	MS Windows XP Pro upgrade	Operating System
82	Symantec	Norton Ghost 2003-CDx	Backup, disaster recovery
1	Symantec	PC Anywhere	Remote Access
1	Symantec	PC Anywhere Host Only v10.5	Remote Access
4	Symantec	PC Anywhere v 10.5 H&R-CD	Remote Access
10	Symantec	PCAnywhereV.10.5 H&R license only	Remote Access
25	Powerquest	Partition Magic	System maintenance
1	Symantec	Procomm PLus 2000 4.8	Communications
1	Adobe	Publishing Collection 12.0 by Adobe Systems	Publication
1	IBM	SIM2000 Upgrade for MVS Operating System	Database
1	Microsoft	SQL Server 2000 Developer ED WNT	Database
1	Microsoft	SQL Server 2000 Developer ED WNT Disk Kit	Database
1	Legato Systems	Support Pack	Backup, disaster recovery
1	Sybase, Inc	Support Renewal for SQL Anywhere	Database
1	Blue Ocean	Track It! Enterprise MS SQL	Helpdesk, Inventory & Purchasing Tracking
4	Blue Ocean	Track It! 100 Audits	Helpdesk, Inventory & Purchasing Tracking
4	Blue Ocean	Track It! Enterprise Add. Users	Helpdesk, Inventory & Purchasing Tracking
8	IDM Computer Solutions	UltraEdit 9.2	ASCII editor
1	IDM Computer Solutions	UltraEdit-32 v10.0	ASCII editor
28	Winzip Computing Inc.	Winzip License	File compression Utility

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APPENDIX K NETWORK COMMUNICATION REQUIREMENTS AND IMAGING WORKSTATIONS

Imaging System

The Claims Imaging System used by ACS is comprised of two pieces - the data entry component and the image storage/retrieval component. The Data Entry component uses software provided by Recognition Research, Inc.; the image storage and retrieval component uses software provided by eServices Group, Inc. The components include:

Hardware:
- 3 Kodak 9500 Document Scanners;
- 2 Kodak 1830 Document Scanners;
- 3 Dell Optiplex G- I Scan servers (for XJ Series scanning);
- 4 Dell Optiplex GX270 Scan servers (for RRI scanning);
- 18 Dell Optiplex GX260 work stations (active keying); and
- 15 Dell Optiplex GX260 work stations (standby keying).

Software:
Recognition Research, Inc provides FormWorks, the data entry system. The keying workstations are connected via a LAN to the RRI servers. The components include:
- Scanning the paper documents;
- Optical Character Recognition (OCR) from the images;
- Keying any fields not recognized by the OCR function or that required human review;
- Generating an image file for later import into a database;
- Generating a data file to be sent to the MMIS mainframe for claims processing; and
- Quality Assurance review of keyed data.

The XJ Series product, provided by eServices Group, Inc, scans other claim documents not requiring keying at the PC level. This includes exam entry and priority claims, and provider enrollment documents. The image generation components include:
- Scanning the paper document; and
- Importing the images from XJ scanning into a database.

The XJ Series software also supports image storage and retrieval, as well as storage and retrieval of mainframe-generated reports. The components for these functions include:
- Importing the images created by the RRI system into a database;
- Importing reports generated by the MMIS mainframe; and
- Thin client web browser-based image and report retrieval system.

All network connectivity is through the ACS network.

Connectivity

- The State of Florida connects to the Metropolitan Area Network (MAN) via a single OC-3 connection at (155 mbps).

- ACS employs a NortelNetworks Backbone Concentrator Node (BCN) to facilitate connectivity to the State of Florida MAN via an ATM Routing Engine (ARE). Router SHCTLHR04 connects to this MAN.
- The ACS BCN attaches to a Cisco Systems Catalyst 4503 at 100Base-T full duplex. Router SHCTLHR04 connects to switch SHCTLHX11 via an external connection.
- Connectivity to ACS systems is provided through a Cisco Systems PIX 525 firewall with hardware redundancy. The Cisco PIX attaches to the 4503 at 100Base-T full duplex and to the ACS network (at Gigabit speeds). It then attaches to a Cisco Systems Catalyst 6513 with redundant supervisor engines. Switch SHCTLHX11I connects to two CISCO Security PIX 525 series firewalls.
- These firewalls connect to ACS router SHCTLHR01 (SHCTLHR02-failover) via gigabit connections.
- ACS router SHCTLHR01 is housed in the same hardware chassis as ACS switch SHCTLHX01.
- The ACS systems within the Edgewater campus are attached directly to the 6513 as up to 100Base-T full duplex; buildings within the campus are also attached to the 6513 via either Cisco Systems Catalyst 4506 or 4503 switches depending on occupancy. ACS switch SHCTLHX01 is connected to the Tallahassee, ACS network via Cat5 (10/100 Mbps).
- The Edgewater campus is connected to the ACS Wide Area Network (WAN) via 4- Frame Relay circuits connecting this site to the ACS Pittsburgh Data Center for access the Mainframe and other ACS systems.

Security

- A Technologic Interceptor is maintained between the ACS network, the Public Internet access provided by Sprint, and the ACS DMZ for publicly available systems.
- ACS users are authenticated to the network via Microsoft Windows NT 4 SP6a, PDC-based user id & password.
- Microsoft Exchange 5.5 antigens are used to block spam & email related viruses from the mail server.
- McAfee Enterprise v7 is used on all LAN connected workstations. The application is set to update at system startup (daily for servers and workstations that are not shut down daily).
- All firewall ports and router external connection ports block all traffic. Ports are only opened when a specific business need and formal request are identified, submitted, approved and processed.
- LAN accounts are removed immediately upon employee termination.
- LAN accounts are audited monthly to ensure terminated employees are fully removed from the LAN.
- LAN passwords adhere to an 8-character, alpha-numeric scheme.

ACS provides VPN access to the network via redundant NortelNetworks Connectivity VPN switches, with authentication being achieved by an RADIUS with RSA SecurelD tokens.

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APPENDIX L MEDICAID ID CARDS AND INSERT SPECIFICATIONS

1. Plastic Card Specifications

   a. Card Stock

   30 ml thickness, copolymer white plastic card, printed two (2) colors on front, two colors (2) on back with protective over laminate, with magnetic stripe. Current card colors are gold for Medicaid recipients, turquoise for Medikids recipients and silver for Silver Saver recipients.

   The card will be printed with information front and back. Variable information will be machine printed via a thermal transfer printing technology using the DataCard Ultragrafix 800 or equivalent equipment.

   b. Variable Data on Card Face

   The following data elements will be printed on the card face by the card production equipment:

	CHARACTERS	FONT
Recipient First Name	12	14
Recipient Middle Name	1	14
Recipient Last Name	12	14
Card Control Number	8	18

   c. Magnetic Stripe Encoding

   Data will be encoded on the magnetic stripe in accordance with ANSI X4.16-1983 track 2 standards.

Start Sentinel	9(1)	Hex B
Number BIN	9(6)	
Case/Cat/Seq	9(13)	
Client Number	9(3)	
Field Separator	9(1)	Hex D
Card Control Number	9(8)	
End Sentinel	9(1)	Hex F
Longitudinal Redundancy Check Character	9(1)	

   A sample of the card is available in the procurement library.

2. Card Carrier - Specifications

   Carrier Stock

   Cards will be machine inserted into a 321b ledger stock manufactured to DataCard Model 2500 specifications. The card will have D hole punches for insertion of up to four cards per carrier.

Carrier forms will be printed two colors on front and one color on back.

3. Envelopes

Carriers will be tri-folded for automated insertion by Pitney Bowes mail preparation equipment. Standard #10 window envelopes, pre-printed with the Agency return address, suitable for machine insertion will be used. A different color envelope will be used to differentiate between Medicaid identification card returns and other return mail.

4. Insert Specifications
   a. Single Card Insert:
      (1) Size of the card should be between:
         (a) Maximum 3 3/4" x 8 3/4"; and
         (b) Minimum 3" x 5 1/2";
      (2) Paper weight should be between:
         (a) Maximum of 90 lb. offset; and
         (b) Minimum of 14 lb. offset;
   b. Single Sheet Letter Size:
      (1) Size of paper should be 8 1/2"x 11";
      (2) Paper should be trifolded not 'z' folded; and
      (3) Paper weight should be between:
         (a) Maximum of 24 lb. or 60 lb. offset; and
         (b) Minimum of 16 lb;
   c. Double Sheet:
      (1) Size of paper should be 17" x 11";
      (2) Paper should be folded in half making its size 8 1/2" x 11"; and
         (a) Paper should then be trifolded not 'z' folded;
      (3) Paper weight should be between:
         (a) Maximum of 24 lb. or 60 lb. offset; and
         (b) Minimum of 16 lb;
   d. Envelopes Inserted with Cards:
      (1) Size of envelope should be between:
         (a) Maximum 3 7/8" x 8 7/8" (No. 9 envelope); and
         (b) Minimum 3" x 5 1/2".

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APPENDIX M CHECKLIST OF MANDATORY ITEMS

This appendix identifies the mandatory items for the Technical and Business Proposals. Failure, in whole or in part, to respond to a specific mandatory item shall result in rejection of either proposal during the evaluation phase.

Checklist of Mandatory Items TECHNICAL PROPOSAL	RESULTS Pass (Yes)	 Fail (No)
GENERAL RESPONSE REQUIREMENTS		
1. Was the proposal received by the State of Florida on the date and time as specified in the Schedule of Activities?		
2. Did the vendor submit separate sealed packages containing the Technical Proposal (and all required documents) and the Cost Proposal?		
3. Did the vendor submit a signed certificate of HIPAA compliance (Attachment B)?		
4. Is a completed Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion form included (Attachment C)?		
5. Is a completed Certification Regarding Lobbying form included (Attachment D)?		
6. Did the vendor submit a signed Certificate of Compliance (Attachment E)?		
7. Is a completed Statement of No Involvement included (Attachment F)?		
8. Did the vendor submit a signed Statement of Drug-Free Work Place (Attachment G)?		
9. Are all other required forms related to corporate contact or corporate reference is included in the proposal (Attachments H, I, J, and K)?		
10. Did the Agency receive the following:		
• A transmittal letter, with an original signature		
• Thirteen (13) copies of the technical proposal (1 original and 12 copies)		
• One electronic version of the technical proposal (diskette or CD-ROM)		

Checklist of Mandatory Items TECHNICAL PROPOSAL	RESULTS	
	Pass (Yes)	Fail (No)
11. Is the Transmittal Letter on the official business letterhead from the entity submitting the proposal as the prime contractor?		
12. Does the Transmittal Letter contain all of the required statements specified in Section 60.2.2?		
13. Is the Transmittal Letter signed by an individual authorized to legally bind the vendor?		
14. If subcontractors are proposed, has each subcontractor submitted a statement, on official letterhead, and signed by an individual authorized to legally bind the subcontractor to perform the scope of work?		
14. Does the vendor appear to be free of additional stipulations, assumptions, and constraints?		
15. Does the technical proposal include a response for each tab listed in Section 60?		
16. Was a proposal guarantee in the amount of $500,000 submitted, with the original of the technical proposal? (Tab 3)		
17. Does the technical proposal include information on the vendor's corporate background and experience? (Tab 4)		
18. Does the technical proposal (Tab 4) include corporate financial statements or an adequate statement as to their omission?		
19. Does the technical proposal include information on the vendor's overall project management plan for the contract? (Tab 5)		
20. Does the technical proposal include information on the vendor's staffing plan? (Tabs 6-13)		
21. Does the vendor agree to comply with the Performance Bond requirement? (Tab 15)		

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Cost Proposal Checklist

Checklist of Mandatory Items COST PROPOSAL	RESULTS Pass (Yes)	 Fail (No)
1. Was the cost proposal received by the Agency no later than the time and date specified in the procurement Timetable?		
2. Were six (6) copies of the Cost Proposal submitted in a separate sealed package? (1 original and 5 copies)		
3. Did the proposal contain a firm, fixed price without any additional stipulations or limitations?		
4. Is there a signed and completed Pricing Schedule for each schedule required by Section 60?		
• Pricing Schedule A		
• Pricing Schedule B		
• Pricing Schedule B-1		
• Pricing Schedule C		
• Pricing Schedule C-1		
• Pricing Schedule C-2		
• Pricing Schedule C-3		
• Pricing Schedule C-4		
• Pricing Schedule C-5		
• Pricing Schedule C-6		
• Pricing Schedule D		
• Pricing Schedule D-1		
• Pricing Schedule E		
• Pricing Schedule E-1		

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APPENDIX N COMPONENTS CROSS REFERENCE

Pharmacy Benefits Management

Requirement	Reference
Process Point of Service (POS) claims And other pharmacy claims	40.1.3.4 FMMIS/DSS Transaction Processing Requirements 40.4.5 Adjudication of Claims
Develop Pro-DUR edits	40.4.2 Service Authorizations 40.4.4 Claims Processing
Apply Pro-DUR edits	40.2.3 Benefit Plan Administration 40.4.5 Adjudication of Claims
Establish Preferred Drug List (PDL)	40.4.3 Cost Avoidance
Maintain the PDL	40.4.3 Cost Avoidance 40.4.4 Claims Processing Administration 40.5.4.6 Health Outcome Measurement Contractor Responsibilities
Negotiate rates with drug companies	40.4.3 Cost Avoidance
Calculate rebates	40.4.3 Cost Avoidance
Bill for and collect rebates	40.4.3 Cost Avoidance
Provide pharmacy and provider academic detailing	40.5.4.6 Health Outcome Measurement
Provide Personal Digital Assistant devices (PDAs) and provide reference software	40.5.4.6 Health Outcome Measurement
Administer lock-in of recipients to a pharmacy	40.2.2.3 Benefit Plan Administration Inputs 40.2.3.6 Benefit Plan Administration Contractor Responsibilities 40.5.5.4 Fraud and Abuse
Execute disease- or diagnosis-based Pharmacy Benefits Management	40.2.3 Benefit Plan Administration 40.4.2 Service Authorizations
Therapeutic Consultation Call Center	40.5.4.6 Health Outcome Measurement (Item 3) Contractor Responsibilities
Pharmacy Field Audits	40.5.4.6 Health Outcome Measurement (Item 4) Contractor Responsibilities
Pharmacy Ombudsman	40.2.8.6 Recipient Communications Contractor Responsibilities

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Decision Support System

Requirement	Reference
Convert all necessary data, beginning upon contract execution; Complete data conversion before Readiness Testing Period (February 2007)	50.1.2.1 Data Conversion
Staff DSS adequately to fulfill service requirements and to meet specific state requirements	Section 50.3 Staffing
Locate DSS activities to conform with state requirements	Section 50.4 Location
Create and operate DSS meeting architecture, performance, processing, data quality control, security, documentation, backup, and continuity of operations requirements set by the state	Section 40.1 General Requirements
Load and synchronize data meeting all translation, mapping and data administration requirements of the state	40.5.2 Data Administration
Meet general query and reporting requirements and provide reporting capabilities and tools set or approved by the state	40.5.2 Data Administration
Monitor the effectiveness of Medicaid administration using reports and systems approved by the state	40.5.3 Management Reporting
Meet all Management, Administration and Reporting Subsystem (MARS) requirements	40.5.3 Management Reporting
Measure the effectiveness of Medicaid services and plans of care, and provide reports for budgeting, forecasting and policy development	40.5.4 Health Outcome Measurement
Compare Florida Medicaid general performance and Benefit Plan performance to national norms and other patterns of care	40.5.4 Health Outcome Measurement
Identify and track fraud and abuse recoveries	40.5.5 Fraud and Abuse Detection

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State Medicaid Manual, Part 11 Subsystems

Requirement	Reference
Recipient Subsystem	40.2 Recipient Management
Provider Subsystem	40.3 Provider Management
Reference Subsystem	40.4.4 Claims Processing Administration 40.5.2 Data Administration 40.5.4 Health Outcome Measurement 40.5.5 Fraud and Abuse Detection
Claims Processing Subsystem	40.4 Payment Management
Management and Administrative Reporting	40.5.3 Management Reporting
Surveillance and Utilization Review Subsystem	40.2 Recipient Management 40.3 Provider Management 40.5 Health Quality, Program Monitoring and Reporting
Contract Management Subsystem	40.1.3 Data Processing Standards 40.5.3 Management Reporting
Third Party Liability Subsystem	40.1.3 Data Processing Standards 40.2.5 Buy-in 40.4 Payment Management
Child Health Check-up	40.2.6 Child Health Check-up
Drug Exception Request Subsystem	40.4 Payment Management
Drug Utilization Review Subsystem	40.5.4 Health Outcome Measurement 40.5.5 Fraud and Abuse Detection
County Billing Subsystem	40.2.9 Recipient Maintenance 40.4.3 Cost Avoidance and Coordination of Benefits 40.5.2 Data Administration
Buy-in Subsystem	40.2.4 Recipient Enrollment 40.2.5 Buy-in

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Medicaid Reform

Requirement	Reference
Provide Medicaid recipients with information to make choices about their health care under Medicaid	40.2.2 Eligibility Determination 40.2.3 Benefit Plan Administration 40.2.4 Recipient Enrollment 40.2.6 Child Health Check-up 40.2.8 Recipient Communications
Provide flexibility in the creation of a wide variety of Benefit Plans, including alternative service networks and managed care options	40.1.3.1 FMMIS/DSS System Architecture Requirements 40.2.3 Benefit Plan Administration 40.5.4 Health Outcome Measurement
Provide increased controls and forecasting capability for managing the state's Medicaid budget and controlling expenditures	40.1.3.1 FMMIS/DSS System Architecture Requirements 40.5.4 Health Outcome Measurement
Provide the capability to calculate risk adjusted premiums and other alternate fee structures	40.1.3.1 FMMIS/DSS System Architecture Requirements 40.5.4 Health Outcome Measurement
Provide for enrollment in a single Benefit Plan, multiple Benefit Plans, or tiered Benefit Plans based on rules that may be changed by state staff to accommodate changes in eligibility requirements, eligibility status or information received on claims	40.2.3 Benefit Plan Administration 40.2.4 Recipient Enrollment
Provide the ability for recipients to compare quality of care among various Benefit Plans	40.2.4 Recipient Enrollment 40.2.8 Recipient Communications
Provide reports to compare the cost-effectiveness of each Benefit Plan, and to calculate savings to the state in each Benefit Plan	40.2.3.6 Benefit Plan Administration Contractor Responsibilities
Provide complete control over the operation of Service Authorizations, Prior Authorizations, Drug Exception Requests, and gate-keeper primary care referrals.	40.4.2 Service Authorization

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APPENDIX O FMMIS/DSS REQUIREMENTS MATRIX

Overview

In order to more effectively assess the technical and functional requirements addressed in this RFP, the State requires all Vendors to complete the following matrix which assists the State is in understanding the degree to which each Vendor's proposed base solution will need to be modified in order to meet the technical and functional requirements addressed in this RFP.

This matrix assumes that for each requirement area, the Contractor will install components from Contractor operations in other states, subcontract with a vendor that has an existing component, and/or install COTS software. For each line in the matrix, the "Base System" refers to these components before any modifications are made for the contract.

Complete the matrix for the following columns:

1. Proposal Section – Reference the section number(s) where your proposal addresses the identified requirement;
2. Modification Complexity – Identify the degree of complexity, using the scale described below, to which the base system and/or the proposed solution meets the identified requirement. The scale to be used is:
    - **1.** Indicates that the base system fully meets the RFP requirement.
    - **2.** Indicates that the base system will require minimal modification (up to 30 FTE workdays) to fully meet the RFP requirement.
    - **3.** Indicates that the base system will require moderate modification (more than 30 FTE and up to 90 FTE workdays) to fully meet the RFP requirement.
    - **4.** Indicates that the base system will require substantial modification (more than 90 FTE workdays) to fully meet the RFP requirement.
    - **5.** Indicates that the vendor will have to create entirely new programs, systems, and screens to meet the requirements.

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RFP Requirement		Proposal Section	Modification Complexity (1 – 5)
40.1 General Technical and Business Process Requirements			
40.1.3.1	FMMIS System Architecture Requirements		
40.1.3.2	DSS System Architecture Requirements		
40.1.3.3	Software/Hardware Configuration		
40.1.3.4	FMMIS/DSS Transaction Processing Requirements		
40.1.3.5	DSS Information Processing Requirements		
40.1.3.6	Programming Language Requirements		
40.1.3.7	System Modification and Change Control Requirements		
40.1.3.8	Application Development and Testing Requirements		
40.1.3.9	Data Imaging and Data Entry Requirements		
40.1.3.10	Data Quality Control		
40.1.3.11	Security and Confidentiality Requirements		
	1. Data Security		
	2. Physical Security		
	3. Disaster Recovery and Back-up		
40.1.3.12	Documentation		
	1. FMMIS/DSS Systems Documentation		
	2. User Documentation		
	3. Software Development Documentation		
40.1.3.13	State Office Automation and Modernization		
40.1.3.14	State Training Requirements		
40.1.5	Standards for MITA Architecture Components		
40.1.5.1	Rules Engine requirements		
40.1.5.2	Workflow Management Engine requirements		
40.1.5.3	Automated Letter Generation		
40.1.5.4	Web Portal		
40.1.5.5	Customer Relationship Management (CRM)		

RFP Requirement		Proposal Section	Modification Complexity (1 – 5)
40.1.5.6	Translators		
40.1.5.7	Desktop Publishing Systems		
40.1.5.8	CBT or Learning Management Systems		
40.1.5.9	Automated, Web-based survey tools		
40.2	**Recipient Management Business Processes**		
40.2.2	Eligibility Determination		
40.2.3	Benefit Plan Administration		
40.2.4	Recipient Enrollment		
40.2.5	Buy-In		
40.2.6	Child Health Check-Up (CHCUP)		
40.2.7	Eligibility Verification		
40.2.8	Recipient Communications		
40.2.9	Recipient Maintenance		
40.3	**Provider Management Business Processes**		
40.3.2	Provider Enrollment Administration		
40.3.3	Provider Enrollment Processing		
40.3.4	Provider Communications		
40.3.5	Provider Maintenance		
40.4	**Payment Management Business Function**		
40.4.2	Service Authorization Business Processes		
40.4.3	Cost Avoidance and Coordination of Benefits (COB)		
40.4.4	Claims Processing Administration		
40.4.5	Adjudication of Claims and Encounters		
40.4.6	Provider Payments		
40.4.7	Adjustments and Voids		
40.4.8	Provider Communications Regarding Payments		
40.5	**Health Quality, Program Monitoring and Reporting**		
40.5.2	Data Administration (Decision Support System)		
40.5.3	Management Reporting		

RFP Requirement		Proposal Section	Modification Complexity (1 – 5)
40.5.4	Health Outcome Measurement		
40.5.5	Fraud and Abuse Detection		

_____

Authorized Representative

_____

Date

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APPENDIX P FORMAT FOR RFP QUESTIONS

Vendors must use this format when submitting written questions to the State regarding the RFP (see Section 20.7). Each Vendor must submit questions numbered in sequential order.

Vendor	Date Submitted	Question #	Section #	Page #	Question	Answer

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