Agency of Human Services
Department of Vermont Health Access (DVHA)
312 Hurricane Lane, Suite 201
Williston, VT 05495
802-879-8256

SEALED BID

INFORMATION TECHNOLOGY REQUEST FOR PROPOSAL

FOR Medicaid Management Information System Design, Development, and Implementation, Medicaid Operations Services, and Integrated Contact Center System and Services

Expected RFP Schedule Summary:

Procurement Schedule	
RFP Release Date	June 30, 2014
Letter of Intent Due - Mandatory	August 7, 2014 (Amended)
Vendor's Questions Due	July 24, 2014
Dept. Responses to Vendor's Questions Posted	August 1, 2014
Vendor's Conference	August 6, 2014
Dept. Responses to Vendor's Conference Questions Posted	August 12, 2014
Proposals Due	**September 11, 2014 (Amended)**
Bid Opening	September 5, 2014
Deadline for Proposal Withdrawal or Modification	September 4, 2014
Vendor's Demonstrations/Oral Presentations	October 28, 29, 2014
Site Visits	November 3-14, 2014
Anticipated Award Announcement	November 18, 2014
Anticipated Contract Start Date	February 3, 2015

LOCATION OF BID OPENING: 312 Hurricane Lane, Suite 201, Williston, VT 05495

PLEASE BE ADVISED THAT ALL NOTIFICATIONS, RELEASES, AND AMENDMENTS ASSOCIATED WITH THIS RFP WILL BE POSTED AT:

http://www.vermontbidsystem.com

THE STATE WILL MAKE NO ATTEMPT TO CONTACT VENDORS WITH UPDATED INFORMATION. IT IS THE RESPONSIBILITY OF EACH VENDOR TO CHECK http://www.vermontbidsystem.com **FOR ANY AND ALL NOTIFICATIONS, RELEASES AND AMENDMENTS ASSOCIATED WITH THE RFP.**

PURCHASING AGENT: Michelle A. Mosher
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1.0 General Information

1.1 Introduction

The State of Vermont, Agency of Human Services, Department of Vermont Health Access (hereinafter called DVHA or the State) is soliciting competitive sealed bids from qualified Vendors for fixed price proposals (Proposals) for a Medicaid Management Information System (MMIS) for the Agency of Human Services (AHS) that includes Software Design, Development and Implementation, and ongoing Technical Support and Medicaid Operations Services.

The MMIS must comply with, and remain in compliance with, the Centers for Medicare and Medicaid Services' (CMS) Seven Conditions and Standards and CMS' Medicaid Information Technology Architecture (MITA) 3.0, or the latest version. In addition, the MMIS needs to closely integrate with Vermont's Health Services Enterprise (HSE). The MMIS must also be certified by CMS, as generally described at http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MMIS/MECT.html

The Medicaid Operations Services Vendor will provide operational support for the Medicaid Management Information System that includes design, development and implementation services, ongoing maintenance and operation support and financial support services. Financial support services include Fiscal Agent services, and similar services for other programs managed through the procured MMIS.

As part of this solicitation, the State is also seeking competitive sealed bids from qualified Vendors for Proposals to implement and operate an integrated customer contact center (Contact Center), including the technologies and technology support to achieve this. The Vendor will provide member and provider Contact Center services for Vermont's publicly funded Green Mountain Care programs, including the Bus Voucher Program, and also will provide these services for Vermont's Health Benefits Exchange (HBE) Qualified Health Plans (QHP).

The State is seeking a range of contemporary and innovative responses which will position it for a rapidly changing environment but which will still provide a low risk approach to more rapid development and deployment of an MMIS than has been the norm in the industry.

If a suitable offer (or offers are) is made in response to this Request for Proposal (RFP), the State may enter into a contract or contracts (the Contract) to have one or more selected Vendors ("bidders" or "Vendors") perform all or part of the Work. This RFP provides details on what is required to submit a Proposal in response to this RFP, how the State will evaluate the Proposals, and what will be required of the Vendor in performing the Work.

The State will consider bids in response to one or both of the following:

- Medicaid Management Information System that includes Software Design, Development and Implementation, and ongoing Technical Support and Medicaid Operations Services
- Implement and operate a customer Contact Center to provide Green Mountain Care member and provider services, including the technology and technology support to achieve this

1.2 Sole point of contact

All communications concerning this RFP will contain the Name and RFP Number in the subject line and will be addressed in writing to the attention of:

Michelle A. Mosher, Purchasing Agent
Department of Vermont Health Access (DVHA)
312 Hurricane Lane, Suite 201
Williston, VT 05495-2087
Michelle.Mosher@state.vt.us
802-878-7957

Michelle A. Mosher, Purchasing Agent is the sole contact for this RFP. Contact with any other State personnel or attempts by bidding Vendors to contact any other State personnel may result in the rejection of their Proposal.

1.3 Procurement Schedule

The following Table 1 documents the critical pre-award events for the procurement and anticipated Contract start date. All dates are subject to change at State of Vermont's discretion.

Table 1. Procurement Schedule

PROCUREMENT SCHEDULE	
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Anticipated Contract Start Date	***February 3, 2015***

1.4 RFP Responses for Portions of this RFP

As the State wishes to receive a broad set of innovative responses, bidders are invited to bid on one or both of the two main components included in this RFP:

- Medicaid Management Information System that includes Software Design, Development and Implementation, and ongoing Technical Support and Medicaid Operations Services
- Implement and operate a Contact Center to provide Green Mountain Care member and provider services, including the technology and technology support to achieve this

Vendors are encouraged to provide the solution that will best help achieve the needs and goals and requirements as stated in the RFP, including the extensibility and adaptability necessary to support the State's envisioned Green Mountain Care 2017

1.5 Letter of Intent to Bid - Mandatory

In order to ensure all necessary communication with the appropriate proposing Vendors and to prepare for the review of proposals, one letter of intent to bid for the scope of this RFP must be submitted per Vendor.

The Vendor must use the Letter of Intent to Bid provided in Template P. In that Template, the Vendor must specify which of the components of the RFP they intend to respond to.

Letters of Intent must be submitted by **August 7, 2014 by 4:30 p.m. EST** to:

Michelle A. Mosher, Purchasing Agent
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495

Or by email at:

Michelle.Mosher@state.vt.us

The State will not entertain Proposals from Vendors that do not submit a Letter of Intent to bid by the date stated.

1.6 State of Vermont Overview

1.6.1 State of Vermont Health System

Spanning more than 9,600 square miles, and home to some 630,000 residents, the State of Vermont is the second least populous state in the country. The State comprises 14 hospitals, 800 primary care providers (PCPs) located in 300 practices and located in 13 hospital service areas. Most PCPs participate in all plans and the health care providers have a strong history of working together.

In addition, Vermont has 11 Federally Qualified Health Centers (FQHCs) with multiple sites, 12 designated agencies that provide mental health as well as developmental disability and substance abuse support- supplemented by others contracted with the State, 5 substance abuse specialty agencies and 3 major health insurance carriers plus Medicaid and Medicare. The hospitals and FQHCs together employ more than two-thirds of the physicians in the state. Vermont is very fortunate to have strong community based organizations providing long-term services and supports and that have garnered national reputations for high performance and outcomes. These networks include 11 designated agencies that provide specialized mental health and substance abuse treatment services, and 5 specialized service agencies that provide developmental services. Other long term support services are provided by 112 residential care homes, 40 nursing homes, 12 home health agencies, five area agencies on aging, 14 adult day providers operating in 16 sites, traumatic brain injury providers and more than 7,500 direct care workers. In addition, Support and Services at Home (SASH) is a partnership led by housing providers that connects affordable housing with health and long term services and supports systems, providing targeted support and services at 112 sites to help participants remain safely at home.

There are also 17 developmental services and mental health agencies, 12 home health providers, over 90 enhanced residential or nursing facility providers involved delivering a continuum of long term services and supports, 5 substance abuse specialty agencies , family agencies, health promotion, school based and residential treatment programs. The three major health insurance carriers in the State plus Medicaid and Medicare, provide funding for health care services in Vermont.

1.6.2 Vermont Health Care Reform

Vermont has a long history of health care reform, beginning in the 1970s with the expansion of Medicaid to cover children and pregnant women. Most recently, Vermont implemented a state-based health insurance exchange, called Vermont Health Connect, pursuant to the Federal Affordable Care Act and enacted legislation creating Green Mountain Care, a new universal, publicly-financed coverage program for all Vermont residents. The most recent coverage legislation is found in 33 V.S.A. chapter 18, subchapters 1 and 2 (or Act 48 of 2011). More information can also be found at: http://hcr.vermont.gov

1.6.3 Act 48 – The Vermont Health Reform Law Of 2011

Act 48 is the key enabling legislation for a universal health system in Vermont. The Act specifically:

- Establishes the Green Mountain Care Board, charged with regulating health insurers and health care providers, to move away from a fee-for-service (FFS) system and control growth in health care costs. The Green Mountain Care Board is responsible to:
  - Improve the health of Vermonters;
  - Oversee a new health system designed to improve quality while reducing the rate of growth in costs;
  - Regulate hospital budgets and major capital expenditures as well as health insurance rates;
  - Approve plans for health insurance benefits in Vermont's new "exchange" program,
  - Approve the Workforce Strategic plan and the HIT plan, both of which are developed by the executive branch and are proposed by AOA, and
- Establishes a Health Benefit Exchange as required by federal law.

The Act outlines the policy choices and supporting technologies that are needed to migrate from the current state of business to the future, universal coverage system to ensure that all Vermonters have health coverage.

1.6.4 Act 171 - An Act Relating to Health Care Reform Implementation

Act 171 is the enabling legislation for Vermont Health Connect, the State's Health Insurance Marketplace. With the establishment of the Marketplace, the State was able to procure and begin to implement the beginnings of the HSE technology and processes, including eligibility determination for Qualified Health Plans and Modified Adjusted Gross Income (MAGI) Medicaid.

Additional technologies and services have the potential for reuse or integration for this MMIS procurement.

1.6.5 AHS' Mission, Structure and Public Medicaid Managed Care Model

AHS is the Agency responsible for health care and human services support across the State and has the statutory responsibility for child welfare and protection, the protection of vulnerable populations, public safety, public health, public benefits, mental health and administration of Vermont's public health insurance system. AHS also serves as the single State Medicaid Agency (SMA).

The State has had a public managed care structure since 2005 and is currently proposing to consolidate long term services and supports and CHIP into the Medicaid Managed Care regulatory framework. Currently Vermont's entire Medicaid program operates under the Global Commitment (GC) to Health Demonstration, with the exception of Long Term Care, DSH and CHIP. The GC Demonstration operates under a managed care model that is designed to provide flexibility with regard to the financing and delivery of health care in order to promote access, improve quality and control program costs. AHS, as Vermont's SMA, is responsible for oversight of the managed care model. DVHA is the entity delegated to operate the managed care model and has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, school health services, and early childhood services).

In addition to state plan Medicaid services and eligibility groups, Vermont also has CMS authorization to administer several "Designated State Health Programs" (DSHP) and to provide an expanded array of Medicaid reimbursement services that do not appear in the state plan. The MMIS must be able to track all AHS/CMS approved services and supports to comply with federal CMS reporting as described in the Special Terms and Conditions of the State's 1115 demonstration and its associated Waiver and Expenditure authority documents.

Payments are not limited to those methodologies described in the Medicaid State Plan. As a public Managed Care Organization (hereinafter referred to as MCO), DVHA and its AHS partners have employed sub-capitated, pay for performance, case rate and other bundled rate payment methodologies for Medicaid State Plan and other specialty programs. The MMIS must be capable of tracking, reporting and disbursing payments outside of a fee for service environment.

As an MCO, the State has authority to invest in programs that will enhance quality and access to services and promote health outcomes. MCO investment payments may be made outside of the MMIS, but will need to be brought together with MMIS information for federal reporting to CMS.

AHS consists of the following Departments with the following responsibilities:

- **Department for Children and Families (DCF)** — DCF provides a wide array of programs and services, including adoption and foster care, child care, child development, child protection, child support, disability determination, and economic benefits such as: Reach Up, Essential Person, General Assistance/Emergency Assistance, 3SquaresVT, Home Heating Assistance and Health Insurance.

- **Vermont Department of Health (VDH)** — VDH sets the State's public health priorities and works with the State to help realize public health goals within the population served by the State. VDH collaborates with the State on clinical initiatives to reduce medical costs in the State through the agency's GC program waiver. These programs include Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and dental care initiatives to children across the State.

- **Department of Corrections (DOC)** — DOC is responsible for managing all adult prisons and community correctional sites. For incarcerated offenders, the department is required and committed to providing basic and humane care that includes comprehensive integrated health and mental health services that are connected with and continue as the individual transitions from or into the community. For offenders in the community, the department is charged with ensuring compliance with conditions by providing or coordinating a variety of support services. The State maintains a unified correctional system with 8 correctional (prison/jails/work-camps) facilities spread out over the State. Each facility provides comprehensive health and mental health services to 8,000+ Vermonters over the course of a year. The majority of offenders entering and leaving corrections are Medicaid eligible.

- **Department of Disabilities, Aging and Independent Living (DAIL)** — DAIL administers all community-based long-term care services for older Vermonters, individuals with developmental disabilities, traumatic brain injuries, physical disabilities, personal care/attendant services, high technology nursing, and the Choices for Care Long Term Care Medicaid Waiver program.

- **Department of Mental Health (DMH)** — DMH is responsible for administering mental health services and programs for children and adults across the State. DMH assures access to mental health services and works closely with multiple human service agencies to coordinate care. The department's work includes designation and collaborative oversight for community-based mental health care and a decentralized, statewide system of inpatient care.

- **Department of Vermont Health Access (DVHA)** — DVHA administers nearly all of the publically funded health care programs for the State of Vermont. Funding of these programs is provided through Medicaid and is authorized under two (2) CMS approved 1115 Demonstration waivers. Several financing mechanisms are outside the 1115

Demonstration waivers and include information technology enhancements, Disproportionate Share Hospital (DSH) payments, and the State Children's Health Insurance Program (SCHIP) services. In addition, DVHA administers the State's health care reform efforts including health information technology (HIT) and health information exchange (HIE) activities in Vermont, the VCCI and the Blueprint for Health.

In addition to the programs listed above, Integrated Family Services (IFS) is an initiative within AHS that ensures services are provided to families in a seamless, integrated way. It encompasses programs within several departments and regionally within several community-based organizations. DCF's Children's Integrated Services (CIS) falls under the IFS umbrella and focuses on prenatal through six (6) years of age.

The AHS Organization Chart can be found in the Procurement Library. In addition to the departments listed above, AHS coordinates closely with the Agency of Education and has long standing interagency agreements related to the use of Medicaid to support EPSDT outreach, school-based health services, early childhood development, mental health, and health promotion.

1.6.6 Agency of One

The "Agency of One" is the approach within the Agency of Human Services that enables our state staff working together with an integration focus to deliver effective client centered experiences. This is discussed in AHS' strategic plan at: http://humanservices.vermont.gov/strategic-plan/ahs-strategic-plan/ahs-strategic-plan/view.

The goals of this approach include:

- **Decrease the lasting impacts of poverty** on individuals, children and families in Vermont and create pathways out of poverty
- **Promote the health, well-being and safety** of individuals, families and our communities
- Enhance AHS's focus on **program effectiveness, accountability** for outcomes, and **workforce development and engagement**
- Ensure that all Vermonters have **access to high quality health care**

The State understands this:

- Requires Accountability: Results Based Accountability
- Emphasizes root causes, prevention & early intervention, not just symptoms
- Involves multiple organizations: AHS, State Government, Community Partners

1.7 Payment and Delivery System Reform Overview

The State of Vermont is committed to moving away from the current fee for service model toward value based purchasing that provides greater incentive for the efficient delivery of health services to Vermonters. The State has taken several steps in this direction and views this work as essential to the success of its health care reform efforts. As such the State seeks an MMIS solution that can support this transition.

1.7.1 The Blueprint for Health

The Blueprint for Health (Blueprint) is Vermont's state-led reform initially focusing on primary care in the State. Originally codified in Vermont statute in 2006, then modified further in 2007, 2008, and finally in 2010 with Vermont Act 128 amending 18 V.S.A. Chapter 13 to update the definition of the Blueprint as a "program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management."

The Blueprint provides support to Vermont's primary care practices to meet the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Standards. In addition, primary care practices, in collaboration with local community partners, plan and develop Community Health Teams that provide multidisciplinary support for PCMHs and their patients. The teams are scaled in size based on the number of patients served by participating practices within a geographic area.

The Blueprint functions as a change agent to support the primary care infrastructure required to optimize care delivery and includes an integrated approach to patient self-management, community development, health care system and professional practice change, and information technology initiatives. It is mandated to become a Statewide service that will encompass pediatric care with an incentive based payment structure.

Further information about the Blueprint initiative can be found at:
http://hcr.vermont.gov/blueprint

1.7.2 State Innovation Model (SIM)

Vermont is actively pursuing a State Innovation Model (SIM) initiative. The goal is to develop a "high performance health system" in Vermont that is governed by a coherent strategy and, from the patient's perspective, achieves full coordination and integration of care throughout a person's lifespan. This concept is consistent with the Institute for Healthcare Improvement's "Triple Aim," which has been embraced by Center for Medicare and Medicaid Innovation (CMMI) and emphasizes: improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

The Blueprint is Vermont's state-led reform initially focusing on primary care in Vermont. Other health care reform information can be found at: http://hcr.vermont.gov

1.7.3 Medicaid Shared Savings Program for Accountable Care Organizations

On October 20, 2011, CMS, an agency within the Federal Department of Health and Human Services (DHHS), finalized new rules under the Affordable Care Act to help doctors, hospitals and other health care providers better coordinate care through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to provide services to an individual Member across the full continuum of care settings such as doctor's offices, hospitals, community-based organizations, as well as long-term care facilities and settings that include a Member's own home.

In 2013, Vermont received $45 million SIM grant from the federal government. This grant will fund activities inside and outside of state government over the next four years to:

1. Increase both organizational coordination and financial alignment between Blueprint advanced primary care practices and specialty care;
2. Implement and evaluate the impact of value-based payment models;
3. Coordinate with those payment models a financing and delivery model for enhanced care management and new service options for dual-eligibles; and,
4. Accelerate development of a Learning Health System infrastructure designed to meet the needs of providers engaged in delivery system reform and the state's needs for ongoing evaluation of the impact of reforms.

Specifically, the grant will support:

- Rapid diffusion of three alternatives to fee-for-service payment:

- Shared savings accountable care payments, under which a single network of providers takes responsibility for managing the costs and quality of care/services for a group of Vermonters;
- Bundled payments, which provide a single payment to a group of providers for an acute or chronic care episode; and
- Pay-for-performance models, which incorporate the total costs and quality of care/services in provider compensation

The State recently developed the Vermont Medicaid Shared Savings Program (VMSSP). To achieve this, the State executed contracts with two organizations to serve as an ACO for the Medicaid population in the VMSSP to improve the quality and value of the care provided to the citizens served by the State of Vermont's public health care programs. This program creates a structure for provider organizations and other participants to join together under an ACO to voluntarily contract with the State to care for Medicaid Members under a payment model that holds the ACO responsible for the total cost of care and quality of services provided to this population. This structure enables the State to implement demonstration projects with one or more ACOs to achieve enhanced integration of health care services and other Medicaid-covered services. Clear incentives for quality of care will be developed to measure improvement in the health and experience of care for individuals. Savings targets were developed to reduce the costs to deliver services and to incentivize efficiencies in the delivery of care.

Additional information on this topic can be found at http://healthcareinnovation.vermont.gov/. The VMSSP contracts can be found here: http://healthcareinnovation.vermont.gov/resources.

1.8 Health Service Enterprise Overview

Innovation is where creativity and passion intersect with opportunity, and Vermont continues to be at the forefront of innovation in health care transformation. Vermont's HSE vision is a multi-year, multi-phased approach that reshapes and integrates current business processes, improves public-private sector partnerships, enhances the utilization of information, modernizes the IT environment, and results in the transformation of the health care experience for the Vermont populace.

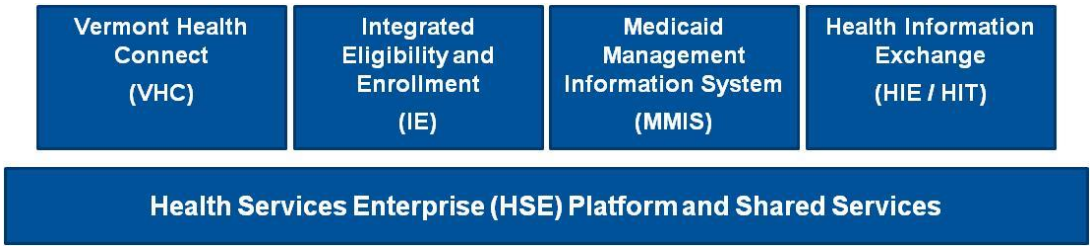
Vermont's aggressive agenda for change is built on providing Vermonters with improved access to their personal health data in a secure, timely and effective manner, enabling services and solutions that result in improved life situations and better health outcomes implemented in conjunction with enhanced access to health care benefits. The HSE strategy is to invest in new and upgraded components and technology that serve the current and near-term needs, and form the technical foundation on which the State can continually evolve to an integrated enterprise within a strategic timeframe. At the same time, these components will help the State transition to support Vermont's envisioned public-private universal health care system.

The HSE is the comprehensive collection of HIT and Health Reform Information Technology systems. Three (3) key components of the HSE are the Vermont Health Connect (VHC) online health insurance marketplace, the Integrated Eligibility (IE) system, and the MMIS (including an enhanced set of provider and member Contact Center capabilities).

These strategic components are incrementally deployed upon Vermont's new service-oriented architecture (SOA) that allows for a modular, flexible, interoperable and learning computing environment, which leverages shared services, common technology, and detailed information. The new environment is designed to be consistent with CMS' MITA 3.0 and Seven Conditions & Standards to ensure the State's ability to meet the goals of increasing electronic commerce and transitioning to a digital enterprise.

As depicted in Figure 1, the Vermont HSE is a combination of building blocks, using the HSE Platform as a foundation. The Platform provides the infrastructure services and functional components that each solution shares.

Figure 1. Health Services Enterprise Overview



A governance structure has been established to support and develop the enterprise vision of the HSE. The HSE Program Management Office (HSE PMO) manages the interaction between the projects through the Program-level lens, and establishes consistent processes, tools and artifacts to manage the cross-project dependencies, funding, reuse and processes, and reflects impacts to, and because of, both business and technology changes. The governance of the Program represents all stakeholder organizations of the HSE and extends through varying levels of government, including the Governor's advisors, the Department of Information and Innovation, and the Agency of Human Services.

A brief Program organizational chart is shown below.

Figure 2. HSE Governance Structure

All projects within the HSE portfolio, and all organizations and vendors working within those projects are expected to comply with and support the governance of the Program in the context of their own project.

1.8.1 Current Related Initiatives

Integrated investment in functional solutions and a standard computing platform is a key enabler for the State to adopt an enterprise approach, and achieve true innovation in health care for the general population. All listed initiatives will have impacts on the scope and functionality needed for the MMIS. Relevant initiatives are listed in the table below.

Table 2. Agency of Human Services' Health Services Enterprise Initiatives

INITIATIVE	DESCRIPTION
Health Services Enterprise (HSE) Platform	The HSE Platform is envisioned as a suite of shared services that are reusable across solutions. Additional details on the Platform are provided below.
Integrated Eligibility (IE)	Vermont currently uses an integrated eligibility system, named ACCESS that is slated for replacement. Both the old and new eligibility systems will provide eligibility processing for the State's health and human services programs.
Vermont Health Connect (VHC)	The State elected to establish a State-run Health Insurance Marketplace, named Vermont Health Connect (VHC). The

INITIATIVE	DESCRIPTION
	initiative provides eligibility determination for Medicaid (based on Modified Adjusted Gross Income MAGI) and the Children's Health Insurance Program (CHIP), Qualified Health Plan, and additional services for non-Medicaid Marketplace activities. VHC passes all Medicaid eligibility determinations to ACCESS (IE) for use by the MMIS. Upon retirement of the ACCESS (IE) legacy system, VHC will pass these determinations to the new integrated eligibility solution.
Green Mountain Care 2017	As part of Act 48, Vermont is preparing to move to a universal, publicly-financed health coverage system in 2017. This approach will ensure that all Vermonters will have coverage based on residency, not based on their employer or employment status. Additional details can be found in other sections of this RFP
Vermont Information Technology Leaders (VITL)	A non-profit organization, VITL is the State's Regional Health Information Organization (RHIO). It is in the process of establishing the State's health information exchange network and is also charged with the development of Vermont's Health Information Technology Plan. VITL has connected almost all of Vermont's 14 hospitals to the Vermont Health Information Exchange. There are also more than 60 Vermont physician practices participating in the exchange, receiving and sending data. The State is an active participant in VITL efforts and the creation of the State plan. Information on the statute authorizing VITL, its organization, and its activities can be found at: http://vitl.net

1.8.2 Design for Reusability.

As an enduring and seldom amended rule and guideline, enterprise architecture frameworks use principles to set about how the enterprise platform fulfills its mission for the business. A fundamental principle followed by the State of Vermont is "Design for Reusability." This principle states that applications developed across the enterprise are preferred over the development of similar or duplicative applications. This principle aligns with CMS' "Leverage Condition" standard which states " solutions should promote sharing, leverage, and reuse of

Medicaid technology and systems within and among state."[1] Therefore, the State of Vermont requires vendors to use the current HSE Platform as noted in the Appendix outline for HSE Platform Reuse.

Please see Vermont's Guide to Reuse:

http://bgs.vermont.gov/sites/bgs/files/pdfs/purchasing/HSEP_Platform_Reuse_Guidance_for_IE_Solution_05_27_14_v4.pdf

1.8.3 Reuse of Existing Technologies

The State has made extensive investments in technologies and services as part of the HSE. While the State encourages innovative approaches to technology and service delivery, it is the State's preference that, to the extent possible and where appropriate, the MMIS and Contact Center will leverage the investments the State has made, either through reuse of technologies already owned, or through the use of Web services available in the Oracle-based SOA-compliant HSE Platform. The following table provides an overview of the envisioned HSE Platform services and capabilities. As these technologies and services are further built out, they will be available for use by HSE solutions, including the MMIS and the Contact Center.

The HSE Platform environments that contain requirements for high availability, run-time performance, disaster recovery, security and general maintenance and operations are the sole responsibility of the State's HSE Platform cloud vendor(s). The HSE Platform, coupled with the VHC business capabilities, have begun the modernization of the health service landscape in Vermont and will provide a stable, scalable, architecture that will accommodate growth and integration of programs that to date have been separate. The State's Enterprise will mature and develop bringing about a greater leverage of shared components. The State will identify and expand the repertoire of common business services and therefore future implementations will utilize a larger pool of common services.

Table 3. HSE Platform Services and Capabilities

Identity Management	Ensure individuals are identified across the range of roles that they play and human services programs that they interact with, and have access only to information and functionality for which they are authorized

[1] CMS Medicaid IT Supplement (MITS-11-01-v1.0)

Consent Management	Ensure that appropriate information is shared with only individuals that are authorized and have a need to access to it
Portal	Provide a consistent user interface and access to information and functionality
Enterprise Information Exchange (EIE)	Also referred to as a gateway, or service bus, which provides a standards based mechanism for integrating with and sharing information among the full range of human services and administrative applications
Master Data Management (MDM)	Includes Master Person Index, and Master Provider Index to ensure a common view and single version of the "truth" across Vermont's AHS programs
Rules Engine	Define and manage the business rules that will drive eligibility assessments across human services programs
Eligibility Automation Foundation	Provide HSE Platform shared functionality for eligibility screening, application and determinations services for Vermont AHS programs
Content Management	Allow management of and access to a wide range of information and media
Analytics and Business Intelligence (BI) Tools and Repositories	Create reports and dashboards to shed light on and manage current operations, and to develop analytical and predictive analyses for future planning and policy development
Collaboration Capabilities	These capabilities include: Service Coordination (Secure Messaging and Shared Case Notes), Client and Provider Look-Up and Query, Referral Management (Create Referral and Manage Referral), and Alerts and Notifications
Service-Oriented Architecture (SOA)	Architected services that are composed of discrete software agents that are loosely coupled to other enterprise components. These services are re-usable for the construction of additional applications.

Universal Customer Management (UCM)	Ensure individual (member) data is managed holistically. This is generally serviced by CRM applications that touch multiple areas of a customer (member) activity. Services to be used include CRM 2.0 capabilities thus offering bi-directional communications and exchanges. This is the backbone of any customer management system.
Enterprise Content Management (ECM) and Customer Communication Management	Allow for the management of structured and un-structured data across the enterprise. The customer communication management part refers to notifications constructed by the business to formally communicate with members by way of the enterprise.
Business Process Management (BPM)	A SOA supported system that generates, stores, and re-uses business processes required to perform the necessary business requirements of the target solution.

1.8.4 Current Technical Environment

The State has adopted a high-level architecture that provides a contemporary and robust approach to meeting Vermont's HSE vision. Detailed descriptions of this architecture are provided in other sections of this document.

The State currently owns licenses for many of the core technologies that are strategic to the HSE. A list of these licenses is located in the Procurement Library. Vendors are strongly encouraged to utilize these technologies in their solution designs.

The State has also defined standards that all procured systems must abide by. These standards can be found in detail at http://dii.vermont.gov/service-catalog. Key standards include:

- SOA Enterprise Service Bus (ESB):
  - ESB support for standard representations including Business Process Execution Language (BPEL), XML Process Definition Language (XPDL), Business Process Modeling Language (BPML) and Web Services Flow Language (WSFL)
  - Adapters need to support SOA services using B2B protocols such as Applicability Statement 1 (AS1)/Applicability Statement 2 (AS2), RosettaNet and Electronic Data Interchange for Administration, Commerce and Transportation (EDIFACT)
- Web Services:

- Web Services Interoperability (WS-I) Organization-compliant implementation of basic Web services standards, including SOAP, WSDL and Universal Description, Discovery and Integration (UDDI), as well as higher-level Web services standards, such as WS-Security
- Representational State Transfer (REST): Support for XML-based message processing as well as HTTP, and XHTML

- Security and Privacy:
  - HIPAA Security and Privacy Rules
  - NIST 800-53A and NIST 800-53 rev3 Moderate baseline
  - IRS pub 1075, which point back to NIST 800-53 rev 3
  - NIST 800-53A rev1 guidance (http://csrc.nist.gov/publications/nistpubs/800-53A-rev1/sp800-53A-rev1-final.pdf) and Harmonized Security and Privacy Framework.
  - CMS requirements, which points back to NIST 800-53 rev3 moderate baseline
  - Guidance from CMS including MITA Framework 3.0 and Harmonized Security and Privacy Framework
- Data Exchange for Clinical Data:
  - Integrating the Health Enterprise (IHE): Cross-Enterprise Document Sharing (XDS, XDS.b); Cross-Community Access (XCA)
  - Health Level Seven (HL7) Continuity of Care Document (CCD) C32 profile

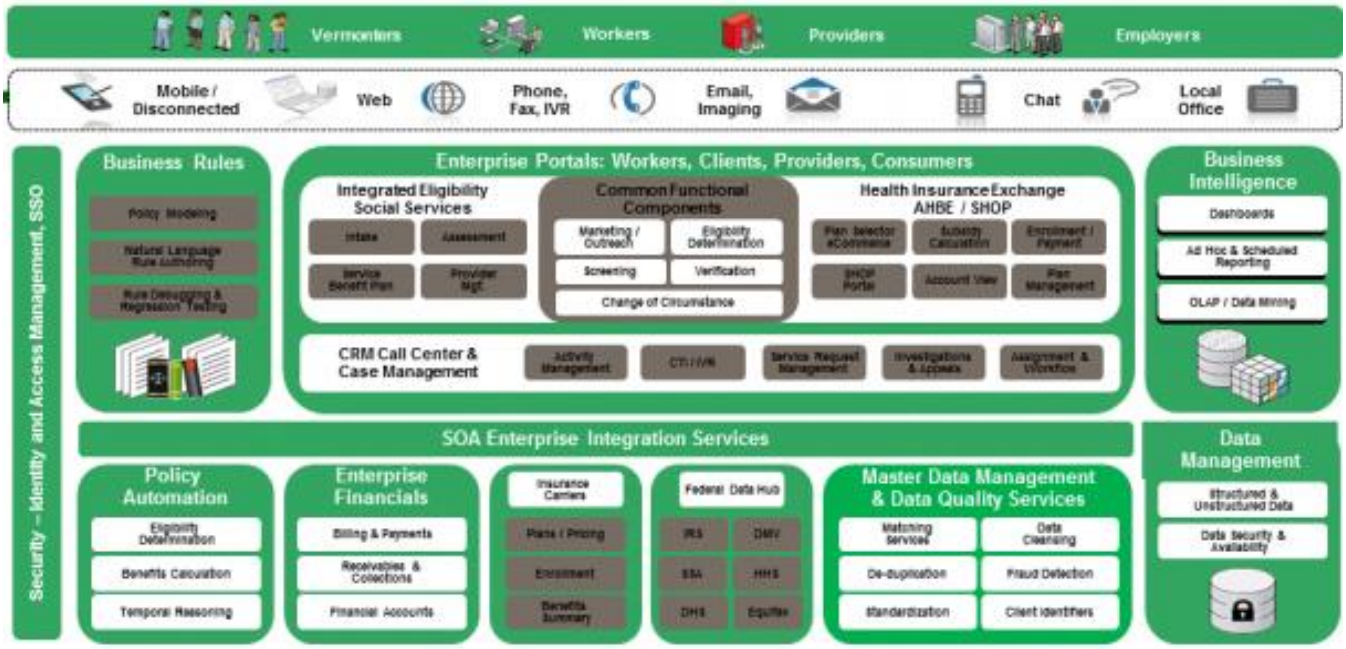
The State currently uses Siebel CRM for Case, BI and Content Management for Vermont Health Connect. The functionality used includes:

- **Workflow (Case) Management**: Currently the VHC application uses a combination of Oracle OPA and Siebel CRM for workflow management. The functionality provided by these components enables the automation of workflows and orchestration of processes associated with eligibility, enrollment, account management, and plan and contract management. Process implementers connect each step of the process to services available through the enterprise service bus and assign tasks to specific users.
- **Business Intelligence and Reporting**: For some reports required by the business, the Siebel CRM native reporting capabilities are used in conjunction with BI Publisher.
- **Enterprise Content Management**: For Document Management purposes the Siebel adapter is used to upload documents (un-structured data) into Web Center. Siebel adds

a service record identifier to a record so both structured and un-structured data can be retrieved.

The HSE Platform Architecture is shown in the figure below.

Figure 3. Vermont's HSE Platform



The HSE Platform project is well underway and the milestones achieved to date include:

1. HSE Platform Hosting Provider (CGI Federal: Phoenix, CFI Federal: SunGard (Philadelphia) Disaster Recovery)

2. Environments contain all application capabilities listed in the following table including, but not limited to, Development, Testing, Training, Staging (mirror Production), Production and Disaster Recovery Environments (mirrored from Production)

Please refer to Vermont's Reuse Guide:

http://bgs.vermont.gov/sites/bgs/files/pdfs/purchasing/HSEP_Platform_Reuse_Guidance_for_IE_Solution_05_27_14_v4.pdf

1.9 Overview of the Current Environment

The Medicaid Enterprise consists of a large number of systems, programs and services that span the State organizations. The following tables describe both the programs with their associated supporting organization, and the technologies that exist today or are planned for future deployment.

The solution will support fully or partially Medicaid funded programs listed in the following table.

Table 4. Partners and Programs in Scope for this Procurement

PRIMARY ORGANIZATION	PROGRAM	ENROLLMENT
Department of Vermont Health Access (DVHA)		
Green Mountain Care Healthcare Programs	Caseload	125,863
	Medicaid Adults	44,153
	MAGI Medicaid (estimated)	35,059
	Dr. Dynasaur	60,495
	State Children's Health Insurance Program (CHIP)	4329
Pharmacy Assistance Programs	Pharmacy Only Programs	12,489
	Healthy Vermonters	6,472
Department of Disabilities, Aging & Independent Living (DAIL)		
	Choices for Care (1115 Long-Term Care Waiver) Programs	5118
	Enhanced Residential Care (ERC)	3875
	Developmental Disability Services	2767
	Adult Day Services, Attendant Services Program and High Technology Home Care	701
Department for Children and Families (DCF)		

PRIMARY ORGANIZATION	PROGRAM	ENROLLMENT
Programs	General Assistance Programs	18,752 households 37,861 grants
	General Assistance Emergency Medical	3,637 grants
	Children's Integrated Services (CIS)	5,000-6,000
Department of Mental Health (DMH)		
Programs	Children's Mental Health Services	11,500
	Community Rehabilitation and Treatment (CRT)	3,000
Department of Education		
Programs	Coordinated School Health Programs (IEP)	13,770
Department of Health (VDH)		
Programs	HIV/Aids Medication Assistance Program (AMAP)	360
	Ladies First	2000
	ADAP Services	6623
	Children's Personal Care Services Needs	2,000

The MMIS solution will eventually also support other non-Medicaid funded programs listed in the following table. These programs are currently not in scope for this procurement, but the procured Systems and Services must be expandable and extensible to support these programs in the foreseeable future.

Table 5. Programs Not in Scope that the Systems and Services must have the Capability to Support in the Future

PROGRAM	SYSTEM EXPECTATIONS
3 SquaresVT (SNAP)	52,382 households 100,020
Reach Up (TANF)	6,314 families 15,028 Recipients
Home Heating Assistance	54,622 households

The State is seeking to consolidate systems that are within the Medicaid enterprise, but are not, or are partially, within in the scope of the current MMIS. The specific functionality of systems that will be required within the MMIS will be determined during the Design, Development, and Implementation (DDI) requirements validation process.

Table 6. Current State Technology Components to be replaced by the MMIS

PRIMARY SUPPORTING STATE ORGANIZATION	VENDOR AND SYSTEM NAME	ADDITIONAL NOTES
DVHA	Hewlett Packard (HP) - MMIS	This system is being re-procured in this RFP
VDH- ADAP	SATIS / TEDS	This data system tracks episodes of care for substance abuse treatment including demographic and health information at admission, service records for each service provided, and demographic and health information at discharge. The admission and discharge information must be reported to SAMHSA as a condition of state receipt of the Substance Abuse Treatment and Prevention Block Grant funding ($5.4 million in FY14). Data is used to manage provider utilization and grants, track statewide trends, and evaluate outcomes.

PRIMARY SUPPORTING STATE ORGANIZATION	VENDOR AND SYSTEM NAME	ADDITIONAL NOTES
DCF	Social Services Management Information System (SSMIS)	This system tracks current and historical client information, case involvement, staff work assignments, court related information, placement and school information, licensing and payee information, generates payments, required federal reporting and claims to federal funding sources.
DMH	Management Service Reports (MSR) & Management Care Information System (MCIS)	This system tracks clinical eligibility, aid category, and service information in order to process Medicaid sub-capitation payments and provide financial monitoring reports and track utilization of services at the provider, client and category of service level of detail
VDH	Ladies First	This program tracks insurance status, service history, client demographics and information for federal reporting on breast and cervical cancer. Ladies First staff also access the Medicaid eligibility system to enroll clients for MMIS service payments.
VDH	VMAP	Vermont Medication Assistance Program (VMAP) is a program administered out of the health department that helps clients living with HIV pay for their insurance premiums, co-pays, deductibles and full cost of medications that are on our approved formulary. Currently, this is accomplished using two programs: 1) A homegrown Access database that tracks client demographic information. 2) A federally sponsored program called CAREWare (CW). CW tracks everything that the Access data base tracks plus medication

PRIMARY SUPPORTING STATE ORGANIZATION	VENDOR AND SYSTEM NAME	ADDITIONAL NOTES
		distribution, medical case management, treatment adherence, medical nutrition therapy and mental health services dates. The CW program is used for federal reporting requirements
VDH	VMD (AIDS)	This program tracks insurance status, service history, client demographics and information for federal reporting and drug payments for AIDS medication
DCF	FSD.net	Contains the following modules: 1. Master client index for FSD 2. Intake – documentation and decision support 3. Child Abuse and Neglect Investigation and Assessments -- documentation and decision support 4. Case notes 5. Health Information Questionnaire 6. Sealed records tracking 7. Some reports
DAIL	HCBS Calculations and Management	The current Excel spreadsheet tracking system will be replaced by the MMIS and will replace the following functions: 1. House demographic information for each client. 2. Track all approved DS waiver plans of care, by client, for each Provider's caseload.

PRIMARY SUPPORTING STATE ORGANIZATION	VENDOR AND SYSTEM NAME	ADDITIONAL NOTES
		3. Enable care plan changes and adjustments 4. Track and approve billing rate changes and all other client budgets on a monthly basis 5. Track and manage Providers' funding allocations 6. Track and manage financials for the program and each DS waiver allocation. 7. Manage funding sources for any changes in funding and all movements of funding allocations between Provider agencies

In addition, the State contracts with a number of vendors to provide services in support of Medicaid and other programs. A list of the current primary technology and services vendors are listed in the following table. A full list of contracts can be found at: http://dvha.vermont.gov/administration/contracts. As a general principle, the State expects that all Vendors will collaborate with each other to achieve the objectives of the State. The Vendor should expect to work with all known and future Vendors.

Table 7. Vermont's Primary Technology and Services Contracts

PRIMARY SUPPORTING STATE ORGANIZATION	VENDOR NAME	SERVICES PROVIDED
DVHA	HP	The State currently has a Fiscal Agent contract with Hewlett-Packard to operate and maintain the State's MMIS (i.e., claims processing, reference, Provider, fiscal management, and reporting subsystems) along with responsibility for Health Insurance Portability and Accountability Act (HIPAA) transaction standards, system maintenance, and designing and implementing modifications and enhancements.

PRIMARY SUPPORTING STATE ORGANIZATION	VENDOR NAME	SERVICES PROVIDED
DVHA	Maximus	The State contracts with MAXIMUS for member services. Since 1995, the State and MAXIMUS have collaborated to develop work plans, policies, procedures and systems to provide outreach, enrollment activities, and member services to Medicaid Members. MAXIMUS provides helpline operations, outreach and education to potential enrollees, and assistance to those inquiring about Medicaid health programs. Maximus has recently been contracted to provide additional support for Vermont Health Connect including member enrollment and support. The Contact Center portion of this RFP will replace the entirety of the Maximus contract.
DVHA	Catamaran	The State currently contracts its Pharmacy Benefits Management services to Catamaran. This contract includes prior authorization processing, claims processing, coordination of benefits, call center support, prospective and retrospective drug utilization review, rebate support, and other core services in support of the pharmacy program in Vermont. This contract has been awarded to GHS.
DVHA	APS	The State contracts with APS to provide supplemental Care Management services for the Vermont Chronic Care Initiative (VCCI). This contract is in the process of being re-procured to expand Care Management technology for the enterprise (AHS) and acquire supplemental services to specifically support the VCCI operations.
DVHA	Myers and Stauffer	The State contracts with Myers and Stauffer LLC to provide cost settlement services.

PRIMARY SUPPORTING STATE ORGANIZATION	VENDOR NAME	SERVICES PROVIDED
DVHA	Benaissance	Benaissance is the State's premium processing vendor. They are responsible for collecting individuals' premium as well as Medicaid premium assistance subsidies (VPAs) to then remit to carriers. All Medicaid payments should have a conduit through the MMIS. Since this premium assistance benefit is new, and since the individuals qualifying for the VPAs do not run through the eligibility system that communicates to the MMIS, there is a current workaround to that eligibility – MMIS validation process. The new MMIS vendor will need to be able to communicate with the Benaissance solution to ensure accurate payment processing.

1.9.1 Key Business Statistics

The State provides a level of support to its Members and Providers that it feels is appropriate for the needs of these stakeholders. Some of the current business process volumes and key statistics are shown in the table below. All volume statistics are annual counts representing SFY 2013 unless otherwise noted.

Table 8. Current Business Process Volumes and Key Statistics

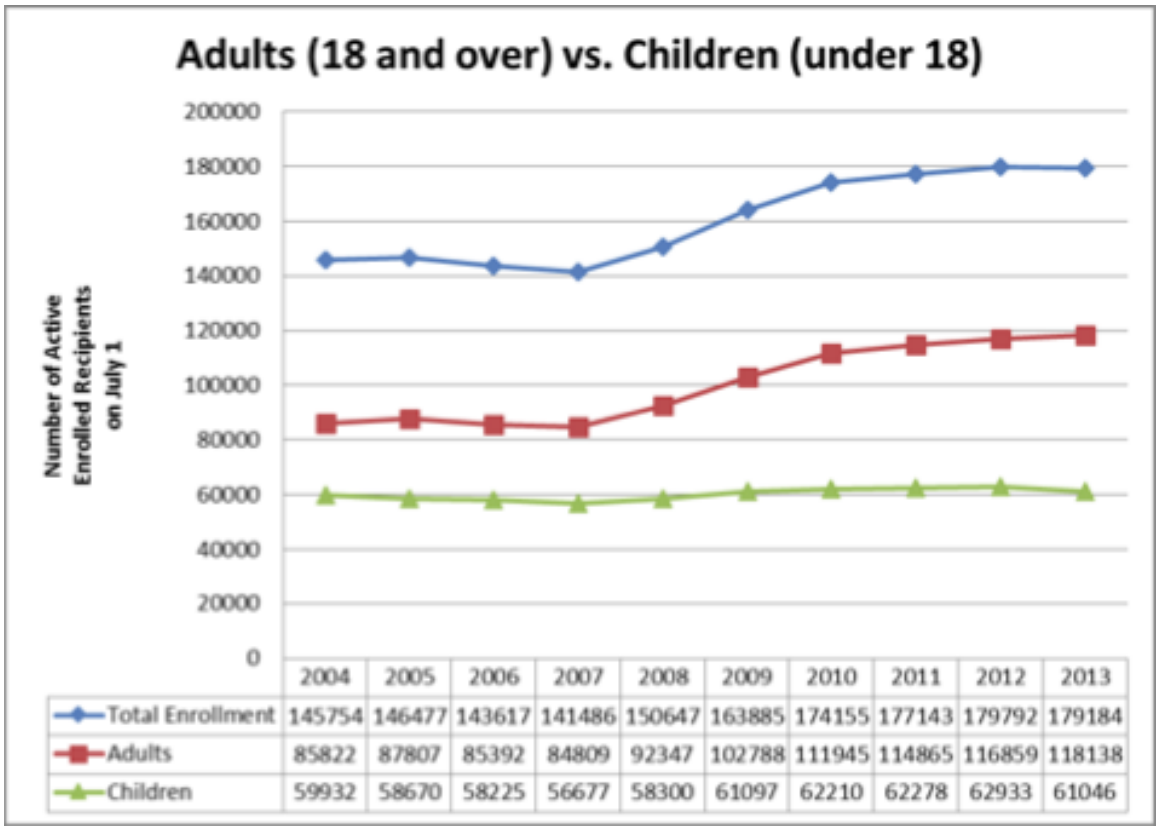
BUSINESS AREA	MEASURE	VOLUME
Member Management	Adults Enrolled	159,585
	Children Enrolled	64,675
Provider Management	Actively Enrolled Providers	12,570
	New Enrollments	2109

BUSINESS AREA	MEASURE	VOLUME
	Recertifications	7290
	Site Visits	338
	Provider Billing Notices Generated	85
Claims and Electronic Eligibility Verification Processing	Claims Adjudicated	9.7 million
	Paper Claims Received	12,885 average per week
	Paper Claims Processed	670,000
	Electronic Claims Processed	6 million
	Electronic Eligibility Verification Requests Processed	5.3 million
Payments	Annual Payment Volume	$1.2 billion
	Weekly Checks Produced	155
	Adjustments Processed	554,967
Third-Party Liability	Recovered from third-parties	5,118,197
Additional Services	Request for Information Processed	4,412
	Enhanced Primary Care Payments	3,856,293
Member Call Center	Peak Hourly Incoming Call Volume	750 (estimated)

BUSINESS AREA	MEASURE	VOLUME
	Lowest Hourly Call Volume during open hours	20 (estimated)
	Peak Call Day	Mondays
	Lowest Volume Call Day	Saturdays
	Average Talk Time Range	12-18 min (estimated)
Fiscal Agent Provider Call Center	Number of Calls Answered by Agents	67,520
	Number of Written Inquiries Responded To	21,781

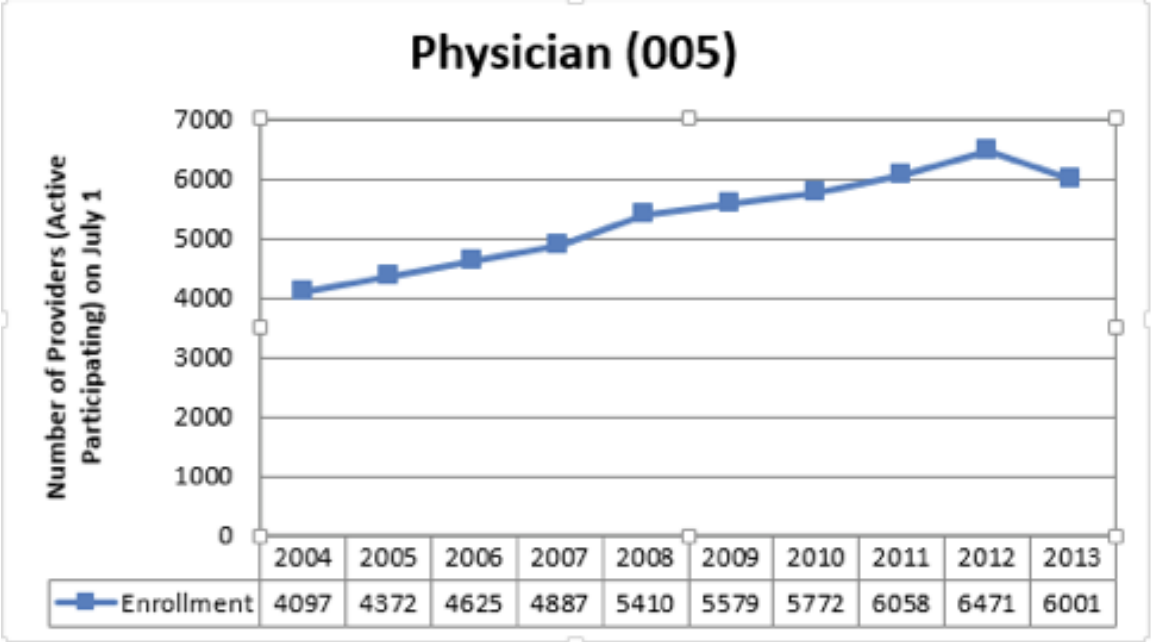
The population of Members and Providers that the State supports is generally trending upward, as described in the Figures below.

Figure 4. Population Served



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Total Enrollment	145754	146477	143617	141486	150647	163885	174155	177143	179792	179184
Adults	85822	87807	85392	84809	92347	102788	111945	114865	116859	118138
Children	59932	58670	58225	56677	58300	61097	62210	62278	62933	61046

Figure 5. Providers Served



1.10 Contract Information

All contract and legal requirements are found in **Template Q — Terms & Conditions of this RFP and Any Resulting Contract**.

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2.0 General Instruction and Proposal Requirements

2.1 Questions and Comments

Any Vendor requiring clarification of any section of this proposal or wishing to comment or take exception to any requirements or other portion of the RFP must submit specific questions in writing no later than **4:30 PM EST on July 24, 2014**. Questions may be e-mailed to Michelle.Mosher@state.vt.us. No questions will be accepted via telephone. Any objection to the RFP or to any provision of the RFP, that is not raised in writing on or before the last day of the question period is waived. Every effort will be made to have the State's responses posted by **August 1, 2014**, contingent on the number and complexity of the questions. A copy of all questions or comments and the State's responses will be posted on the State's website:

http://www.vermontbidsystem.com

2.2 Letter of Intent to Bid - Mandatory

Vendors are required to submit a Letter of Intent to Bid.

The Vendor must use the Letter of Intent to Bid provided in Template P. In that Template, the Vendor must specify which of the components of the RFP they intend to respond to.

Letters of Intent must be submitted by **August 7, 2014 by 4:30 p.m. EST** to:

Michelle A. Mosher, Purchasing Agent
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495

Or by email to

Michelle.Mosher@state.vt.us

2.3 Vendor Conference

A pre-proposal Vendor Conference has been scheduled for **August 6, 2014 at 1:00 PM EST.**

Call in number: 877 273-4202

PIN: 967-173-362

While attendance is not mandatory, interested Vendors are highly encouraged to participate in this conference call. Interested firms will have the opportunity to submit questions regarding the RFP requirements during the call. A sound recording of the meeting will be distributed upon

request and official DVHA Responses to questions posed at Vendor's conference will be posted on the DVHA website on **August 12, 2014** by close of business. Substantial clarifications or changes required as a result of the meeting will be issued in the form of a written addendum to the RFP.

2.4 Modification or Withdrawal of Proposal

Prior to the proposal submission deadline set forth in this RFP, a Vendor may: (1) withdraw its Proposal by submitting a written request to the State point of contact, or (2) modify its Proposal by submitting a written amendment to the State point of contact. The State may request proposal modifications at any time.

The State reserves the right to waive minor informalities in a Proposal and award a Contract that is in the best interest of the State of Vermont. A "minor informality" is an omission or error that, in the State's determination, if waived or modified when evaluating proposals, would not give a Vendor an unfair advantage over other Vendors or result in a material change in the Proposal or RFP requirements. When the State determines that a Proposal contains a minor informality, it may at its discretion provide the Vendor with the opportunity to correct.

2.5 Amendments and Announcements Regarding this RFP

The State will post all official communication regarding this RFP on its website (http://www.vermontbidsystem.com), including any notice of tentative award. The State reserves the right to revise the RFP at any time. Any changes, amendments, or clarifications will be made in the form of written responses to Vendor questions, amendments, or addenda issued by the State on its website. Vendors should check the website frequently for notice of matters affecting the RFP.

Any contract resulting from this RFP will be between the State of Vermont and the selected Vendor. Any requirements specified herein post award are specifically by and between the State of Vermont and the selected Vendor.

2.6 Multiple Responses

If there is a successful joint proposal for either of the two RFP Components, or for both components by two (2) or more organizations, one (1) organization must be designated as the Prime Bidder. The Prime Bidder will be the State's sole point of contact for the RFP Components being awarded and will bear sole responsibility for performance under any resulting agreement.

The Vendor may only submit one (1) Proposal as a prime Vendor. If the Vendor submits more than one (1) proposal as a prime, the State may reject one or more of the submissions. This

requirement does not limit a Vendor's ability to collaborate with one or more Vendors as a Subcontractor submitting proposals.

2.7 Use of Subcontractors

Subject to the conditions listed in this RFP, the Vendor may propose to use a Subcontractor(s) to make a complete offer to perform all services. Any prospective Subcontractor that is not a wholly owned subsidiary of the Vendor will be subject to these conditions.

The conditions for proposing to use Subcontractors include, but are not limited to, the following:

1. Prior to any communication or distribution of State confidential information to the potential Subcontractor, the Vendor must provide the State with the name of the potential Subcontractor in advance and in writing. The Vendor will also provide contact information for the potential Subcontractor.

    a. The State must give its written approval prior to the Vendor providing any State confidential information to a potential Subcontractor or another entity.

2. If selected, the Vendor will be the prime Vendor for services provided to the State by approved Subcontractors.

3. The Vendor will be ultimately responsible for the provision of all services, including Subcontractor's compliance with the service levels, if any.

4. Any Subcontractor's cost will be included within the Vendor's pricing and invoicing.

No subcontract under the Contract must relieve the Vendor of the responsibility for ensuring the requested services are provided. Vendors planning to subcontract all or a portion of the Work to be performed must identify the proposed Subcontractors.

2.8 Interpretive Conventions

Whenever the terms "must," "shall," "will" or "is required" are used in this RFP in conjunction with a specification or performance requirement, the specification or requirement is mandatory. A Vendor's failure to address or meet any mandatory requirement in a proposal may be cause for the State's rejection of the Proposal.

Whenever the terms "can," "may," or "should" are used in this RFP in conjunction with a specification or performance requirement, the specification or performance requirement is a desirable, but not mandatory, requirement. Accordingly, a Vendor's failure to address or provide any items so referred to will not be the cause for rejection of the Proposal, but will likely result in a less favorable evaluation.

2.9 Instructions for Submitting Proposals

2.9.1 Number of Copies

The Vendor is required to submit one (1) clearly marked original Proposal and fifteen (15) identical copies of the complete Proposal, including all sections and exhibits, in three-ring binders, and one (1) electronic copy on a portable medium such as a compact disk.

The bid should include a Technical Response and a separate Cost Response. The State will not accept electronic and facsimile proposals. Any disparities between the contents of the original printed Proposal and the electronic Proposal will be interpreted in favor of the State.

2.9.2 Submission

All bids must be sealed and addressed to:

Department of Vermont Health Access (DVHA)
Michelle A. Mosher, Procurement Manager
312 Hurricane Lane
Williston, VT 05495-2087
Michelle.Mosher@state.vt.us

802-878-7957

PROPOSALS DUE: SEPTEMBER 11th, 2014 by 1:00 PM EST – we will not accept late proposals.

BID ENVELOPES MUST BE CLEARLY MARKED 'SEALED BID' AND SHOW THE REQUISITION NUMBER AND/OR PROPOSAL TITLE, OPENING DATE AND NAME OF VENDOR.

All Vendors are hereby notified that sealed bids must be received and time stamped by DVHA Business Office located at 312 Hurricane Lane – Williston, VT 05495 by the time of the bid opening. Bids not in possession of the Office of Purchasing & Contracting at the time of the bid opening will be returned to the Vendor, and will not be considered.

Office of Purchasing & Contracting may, for cause, change the date and/or time of bid openings or issue an addendum. If a change is made, the State will make a reasonable effort to inform all Vendors by posting at: http://www.vermontbidsystem.com

The bid opening will be held on **September 5, 2014 at 1:15 PM EST at 312 Hurricane Lane, Suite 201, Williston, VT 05495 and is open to the public**. Typically, the State will open the bid and read the name and address of the Vendor. Bid openings are open to members of the public. However no further information which pertains to the bid will be available at that time other

than the name and address of the Vendor. The State reserves the right to limit the information disclosed at the bid opening to the name and address of the Vendor when, in its sole discretion, it is determined that the nature, type, or size of the bid is such that the State cannot immediately (at the opening) establish that the bids are in compliance with the RFP. As such, there will be cases in which the bid amount will not be read at the bid opening. Bid results are a public record. However, the bid results are exempt from disclosure to the public until the award has been made and the Contract is executed with the apparently successful Vendor.

2.9.2.1 Delivery Methods

U.S. MAIL: Vendors are cautioned that it is their responsibility to originate the mailing of bids in sufficient time to ensure bids are received and time stamped by the DVHA Business Office prior to the time of the bid opening.

EXPRESS DELIVERY: If bids are being sent via an express delivery service, be certain that the RFP designation is clearly shown on the outside of the delivery envelope or box. Express delivery packages will not be considered received by the State until the express delivery package has been received and time stamped by the DVHA Business Office.

HAND DELIVERY: Hand carried bids shall be delivered to the Procurement Officer or their designee prior to the bid opening.

ELECTRONIC: Electronic bids will not be accepted.

FAXED BIDS: Faxed bids will not be accepted.

2.9.2.2 Proposal Submission Requirements

Vendors must strictly adhere to the following response submission requirements:

1. Failure to follow any instruction within this RFP may, at the State's sole discretion, result in the disqualification of the Vendor's Proposal.

2. The State has no obligation to locate or acknowledge any information in the Vendor's Proposal that is not presented under the appropriate outline according to these instructions and in the proper location.

3. The Vendor's Proposal must be received, in writing, at the address specified in this RFP, by the date and time specified. The State WILL NOT BE RESPONSIBLE FOR DELAYS IN THE DELIVERY OF DOCUMENTS. Any Proposal received after proposal opening time will be returned unopened.

4. Proposals or alterations by fax, e-mail, or phone will not be accepted.

5. Original signatures are required on one (1) copy of the Submission Cover Sheet and Template Q, and Vendor's original submission must be clearly identified as the original.

6. The State reserves the right to reject any proposals, including those with exceptions, prior to and at any time during negotiations.

7. The State reserves the right to waive any defect or irregularity in any proposal procedure.

8. The Vendor must not alter or rekey any of the original text of this RFP. If the State determines that the Vendor has altered any language in the original RFP, the State may, in its sole discretion, disqualify the Vendor from further consideration. The RFP issued by the State of Vermont is the official version and will supersede any conflicting RFP language submitted by the Vendor.

9. To prevent opening by unauthorized individuals, all copies of the Proposal must be sealed in the package. A label containing the information on the cover page must be clearly typed and affixed to the package in a clearly visible location.

10. The Vendor acknowledges having read and accepted all sections by signing Template A and Q.

It is the responsibility of the Vendor to clearly identify all costs associated with any item or series of items in this RFP. The Vendor must include and complete all parts of the Cost Proposal in a clear and accurate manner.

Omissions, errors, misrepresentations, or inadequate details in the Vendor's Cost Proposal may be grounds for rejection of the Vendor's Proposal. Costs that are not clearly identified will be borne by the Vendor.

2.9.3 Additional Information or Clarification

The State reserves the right to request additional information or clarification of a Vendor's Proposal. The Vendor's cooperation during the evaluation process in providing State staff with adequate responses to requests for clarification will be considered a factor in the evaluation of the Vendor's overall responsiveness. Lack of such cooperation may, at the State' discretion, result in the disqualification of the Vendor's Proposal.

1. Vendors may request additional information or clarifications to this RFP using the following procedures:

    a. Vendors must clearly identify the specified paragraph(s) in the RFP that is/are in question.

b. Vendors must deliver a written document to the sole point of contact as identified in Section 1.2 of this RFP.

c. This document may be delivered by hand, via mail or e-mail, The State WILL NOT BE RESPONSIBLE FOR DELAYS IN THE DELIVERY OF QUESTION DOCUMENTS.

d. It is solely the responsibility of the Vendor that the clarification document reaches the State on time. Vendors may contact the sole point of contact to verify the receipt of their documents. Documents received after the deadline will be rejected. All questions will be compiled and answered and a written document containing all questions submitted and corresponding answers will be posted on the State's website (http://www.vermontbidsystem.com).

Unsolicited clarifications and updates submitted after the deadline for responses will be accepted or rejected at the sole discretion of the State.

2.10 Proposal Instructions

Proposals must address all the requirements of the RFP in the order and format specified in this section. Each RFP requirement response in the Proposal must reference the unique identifier for the requirement in the RFP.

It is the Vendor's responsibility to ensure its Proposal is submitted in a manner that enables the Evaluation Team to easily locate all response descriptions and exhibits for each requirement of this RFP. Page numbers should be located in the same page position throughout the Proposal. Figures, tables, charts, etc. should be assigned index numbers and should be referenced by these numbers in the Proposal text and in the Proposal Table of Contents. Figures, tables, charts, etc. should be placed as close to text references as possible.

Unless otherwise specified, Proposals shall be on 8-1/2" x 11" white bond paper with no less than ½" margins and eleven (11) point font. Pages shall be consecutively numbered within the bottom or top margin of each page, including attachments, such that if the document became separated, it could easily be put back together. Hard copy proposals are to be assembled in loose-leaf, three-hole punch binders with appropriate tabs for each volume and section. Do not provide proposals in glue-bound binders or use binding methods that make the binder difficult to remove.

At a minimum, the following should be shown on each page of the Proposal:

1. RFP #
2. Name of Vendor
3. Page number

Proposals in response to this RFP must be divided into two (2) appropriately labeled and sealed packages marked Technical Proposal and Cost Proposal. All proposal submissions should be clearly labeled with the RFP number.

The contents of each package must be as follows:

1. **Package 1 – Technical Proposal**

   Technical Proposal addressing all requirements specified in the RFP using the response forms provided in Templates A through N, and Q.

2. **Package 2 — Cost Proposal**

   Cost Proposal provided using the form supplied in Response Template O.

2.10.1 Proposal Format

The Proposal must be structured in the following manner and must consist of all the sections, separated into two (2) packages as listed below:

Package 1 - Technical Proposal

This package of the Vendor's response must include Sections A through N as described below. Each section corresponds to the **Response Template** designated with the same letter.

Section A. RFP Cover Letter and Executive Summary

This section of the Vendor's Technical Proposal must include a cover letter and executive summary stating the Vendor's intent to bid for this RFP.

The Vendor's response must include a transmittal (cover) letter; table of contents; executive summary; Vendor contact information and locations.

Submission for this section must be compliant with the instructions detailed in Response Template A – Cover Letter and Executive Summary.

Section B. Vendor Experience

This section of the Vendor's Technical Proposal must include details of the Vendor's Experience.

The Vendor's response must include Vendor organization overview; corporate background; Vendor's understanding of the HHS domain; and Vendor's experience in public sector.

Submission for this section must be compliant with the instructions detailed in Response Template B - Vendor Experience.

Section C. Vendor References

This section of the Vendor's Technical Proposal must include Vendor's References.

The Vendor's response must include at least three (3) references from projects performed within the last five (5) years that demonstrate the Vendor's ability to perform the Scope of Work described in the RFP. If the Proposal includes the use of Subcontractor(s), provide three (3) references for each. Vendors responding to both components of this RFP must provide three (3) references for each component of the RFP responding to, although these references may overlap (e.g., a single reference demonstrates a Vendor's ability to perform for both components of the Work) such that a Vendor responding to both components will not necessarily require six (6) references.

Submission for this section must be compliant with the instructions detailed in Response Template C – Vendor References.

Section D. Subcontractor Letters

This section of the Vendor's Technical Proposal must include a letter of the Vendor's proposed Subcontractor(s) that will be associated with this Contract.

Submission for this section must be compliant with the instructions detailed in the Response Template D – Subcontractor Letters.

Section E. Vendor Organization and Staffing

This section of the Vendor's Technical Proposal must include a narrative of the Vendor's proposed Organization and Staffing approach to meet the State's System requirements.

The Vendor's response must include the proposed approach to: organization plan; organization chart; key staff; Subcontractors; staff contingency plan; staff management plan; staff retention and the Vendor's approach to working with the MMIS Project staff.

Submission for this section must be compliant with the instructions detailed in the Response Template E – Vendor Project Organization and Staffing.

Section F. Staff Experience

This section of the Vendor's Technical Proposal must include a narrative of the Vendor's Staff Experience.

The Vendor's response must include the proposed approach to: roles and responsibilities; summary of skill sets; total years of experience in the proposed role; qualifications and resumes.

Submission for this section must be compliant with the instructions detailed in Response Template F – Staff Experience.

Section G.1. MMIS Functional System Requirements

This section of the Vendor's Technical Proposal must include a response to the Functional Requirements provided in Response Template G.1 – MMIS Functional System Requirements. The objective of the Template response is to provide the State team with a structured response that will allow them to understand the degree to which each Vendor's approach has the potential of meeting the State Project requirements.

The 'Response Columns' within each tab of the Functional Requirements matrix must be completed by the Vendor as described in the instructions detailed in Response Template G.1 – MMIS Functional System Requirements.

Section G.2. Medicaid Operations Services Functional Service Requirements

This section of the Vendor's Technical Proposal must include a response to the Functional Requirements provided in Response Template G.2 – MMIS Functional Service Requirements. The objective of the Template response is to provide the State team with a structured response that will allow them to understand the degree to which each Vendor's approach has the potential of meeting the State Project requirements.

The 'Response Columns' within each tab of the Functional Requirements matrix must be completed by the Vendor as described in the instructions detailed in Response Template G.2 – MMIS Functional Service Requirements.

Section G.3 Contact Center Functional Requirements

This section of the Vendor's Technical Proposal must include a response to the Functional Requirements provided in Response Template G.3 –Contact Center Functional Requirements. The objective of the Template response is to provide the State team with a structured response that will allow them to understand the degree to which each Vendor's approach has the potential of meeting the State Project requirements.

The 'Response Columns' within each tab of the Functional Requirements matrix must be completed by the Vendor as described in the instructions detailed in Response Template G.3 – Contact Center Functional System Requirements.

Section H.1. MMIS Functional Requirements Approach

This section of the Vendor's Technical Proposal must include narrative of the Vendor's proposed Functional Requirements approach. In response to Response Template H.1 – MMIS Functional Requirements Approach, the Vendor must provide a narrative overview of how the proposed

System will meet the State's functional requirements. The Vendor must complete this response section as a part of its response.

Submission for this section must be compliant with the instructions detailed in Response Template H.1 – MMIS Functional Requirements Approach.

Section H.2. Medicaid Operations Services Requirements Approach

This section of the Vendor's Technical Proposal must include narrative of the Vendor's proposed Services Requirements approach. In response to Response Template H.2 – MMIS Services Requirements Approach, the Vendor must provide a narrative overview of how the proposed approach will meet the State's Medicaid Operations Services service requirements. The Vendor must complete this response section as a part of its response.

The Vendor's response must include the proposed approach to: organization plan; organization chart; key staff; Subcontractors; staff contingency plan; staff management plan; staff retention and the Vendor's approach to working with the MMIS staff.

Submission for this section must be compliant with the instructions detailed in Response Template H.2 – MMIS Services Requirements Approach.

Section H.3. Contact Center Functional Requirements Approach

This section of the Vendor's Technical Proposal must include narrative of the Vendor's proposed Functional Requirements approach. In response to Response Template H.3 – Contact Center Functional Requirements Approach, the Vendor must provide a narrative overview of how the proposed System and Services will meet the State's functional requirements. The Vendor must complete this response section as a part of its response.

Submission for this section must be compliant with the instructions detailed in Response Template H.3 – Contact Center Functional Requirements Approach.

Section I. Non-Functional Requirements

This section of the Vendor's Technical Proposal must include a response to the Technical Requirements provided in Response Template I – Non-Functional Requirements. The following section provides Vendor instructions for preparing the response.

The objective of the Technical Requirements response is to provide the MMIS team with a method to evaluate the degree to which each Vendor's System satisfies the MMIS Technical Requirements.

The 'Response Columns' within each tab of the Non-Functional Requirements matrix must be completed by the Vendor as described in the instructions detailed in Response Template I – Non-Functional Requirements.

Section J. Technical Requirements Approach

This section of the Vendor's Technical Proposal must include a narrative of the Vendor's proposed Technical Requirements approach. Submission for this section must be compliant with the instructions detailed in Response Template J – Technical Requirements Approach.

Section K. Implementation Requirements Approach

This section of the Vendor's Technical Proposal must include a narrative of the Vendor's proposed Implementation approach. Submission for this section must be compliant with the instructions detailed in Response Template K – Implementation Requirements.

The Vendor's response must detail the approach to meet the various Implementation Requirements including: project management methodology; detailed requirements document; system designs; software installation and configuration; development methodology; user, administrator and developer training; testing; conversion planning and support; deployment and go-live support; and change management.

Section L. Warranty, Software Maintenance and Operations Support Approach

This section of the Vendor's Technical Proposal must include a narrative of the Vendor's proposed Warranty, Software Maintenance and Operations Support approach. Submission for this section must be compliant with the instructions detailed in Response Template L – Maintenance Requirements Approach.

The Vendor's response must detail the approach to meet the various Warranty, Software Maintenance and Operations requirements including: defect removal; corrective maintenance; warranty requirements; adaptive maintenance; availability of staff, lead time for on-boarding of staff, staff due diligence process, knowledge transfer and documentation processes.

Section M. Work Plan

This section of the Vendor's Technical Proposal must include a Work Plan that will be used to create a consistent and coherent management plan. This Work Plan will demonstrate that the Vendor has a thorough understanding for the Scope of Work and what must be done to satisfy the project requirements. Submission for this section must be compliant with the instructions detailed in Response Template M – Work Plan.

The Work Plan must include detail sufficient to give the State an understanding of how the Vendor's knowledge and approach will:

- Manage the Work;
- Guide Work execution;
- Document planning assumptions and decisions;
- Facilitate communication among stakeholders; and
- Define key management review as to content, scope, and schedule.

Section N. RFP Response Checklist and Supplements

This section of the Vendor's Technical Proposal must include the completed checklist verifying that all the RFP response requirements as part of Templates A through P and the RFP Attachments have been completed. Submission for the Proposal Checklist and Supplements must be compliant with the instructions detailed in Response Template N – RFP Response Checklist.

Section Q. Terms & Conditions of this RFP and Any Resulting Contract

This section of the Vendor's Technical Proposal includes the completed signed legal and contracting requirements.

The Vendor must sign and review Template Q- Terms & Conditions of this RFP and Any Resulting Contract in order to note Vendor's acknowledgment, intent of compliance, and/or exceptions to the following: (1) RFP Terms & Conditions; (2) Mandatory Contract Terms; (3) Standard State Provision for Contracts and Grants; and (4) General Terms & Conditions.

Package 2 - Cost Proposal

This package of the Vendor's response must include Response Template O – Cost Workbook as described below.

Section O. Cost Proposal Instructions

The Cost Proposal must include a response through the submission of Response Template O – Cost Workbook. Vendors must complete this workbook as instructed and place it in a separate, sealed package, clearly marked as the Cost Proposal with the Vendor's name, the RFP number, and the RFP submission date.

Vendors must base their Cost Proposals on the Scope of Work described in Section 2.0 and associated sections of this RFP and Templates. The Cost Proposals must include any business, economic, legal, programmatic, or practical assumptions that underlie the Cost Proposal. The State reserves the right to accept or reject any assumptions. All assumptions not expressly

identified and incorporated into the Contract resulting from this RFP are deemed rejected by the State.

Vendors are responsible for entering cost data in the format prescribed by Response Template O - Cost Workbook. Formulas have been inserted in the appropriate cells of the worksheets to automatically calculate summary numbers, and should not be altered. Further instructions for entering cost data are included in the worksheets. It is the sole responsibility of the Vendor to ensure that all mathematical calculations are correct and that the Total Costs reflect the Bid Amount(s) for responses to this RFP, or portions thereof.

Completion of the Cost Workbook and worksheets is mandatory. Applicable purchase, delivery, tax, services, safety, license, travel, per diem, Vendor's staff training, Project facility, and any other expenses associated with the delivery and implementation of the proposed items must be included in the Vendor's costs and fixed Hourly Rates.

The Cost Proposal MUST BE A SEPARATE SUBMISSION. No cost information can be contained in the Technical Proposal submission. If there is cost information in the Technical Proposal, the Vendor can be disqualified from consideration.

The Cost Proposal must include the costs for the MMIS, Medicaid Operations Services and Contact Center System and Services, in alignment with the selected Response Type and as instructed in Template O.

Medicaid Management Information System

The MMIS includes Implementation, Software M&O Support, Software, and Hardware. The Vendor must include all one-time and ongoing costs in the Cost Proposal. Total Costs are required by the State for evaluation and budget purposes, and for an overall understanding of how they are derived. Costs must be based on the terms and conditions of the RFP, including the State's General Provisions and Mandatory Requirements of the RFP (not the Vendor's exceptions to the terms and conditions). The Vendor is required to state all other assumptions upon which its pricing is being determined in the Response Template O – Cost Workbook and Cost Assumptions. Assumptions must not conflict with the RFP terms and conditions including the State's General Provisions or Mandatory Requirements of this RFP.

Vendors are required to provide costs for all phases, which must be firm fixed price with payments based on deliverables as proposed by the Vendor. The ongoing Software Maintenance payments must be monthly (based on hours invoiced) for the number and type of Vendor Software Maintenance staff positions to be specified by the Vendor throughout the Contract period. The Vendor must provide fixed Hourly Rates to the State for work to be performed during each phase separately from work to be performed during the Software Maintenance period. In addition, fixed Labor rates must be available for the State to use for Unanticipated

Tasks as necessary. The Vendor is required to provide costs for Packaged Software and Hardware. The Vendor must provide costs for the DDI Hosting and Disaster Recovery Services.

The Vendor is required to provide at least one Program Integrity solution as part of this Proposal. Additional solutions may be proposed and costed which will be evaluated at the discretion of the State.

MMIS Medicaid Operations Services

The ongoing Services must be proposed in monthly quantities in units proposed by the Vendor (e.g., such measures as number and type of Vendor staff positions, transaction volumes, population base, etc.) to be specified by the Vendor.

If relevant, the Vendor must provide fixed Hourly Rates to the State for work to be performed. In addition, fixed Labor rates must be available for the State to use for Unanticipated Tasks as necessary.

Contact Center System(s)

The Contact Center must include Implementation, Software M&O Support, Software, and Hardware. The Vendor must include all one-time and ongoing costs in the Cost Proposal. Total Costs are required by the State for evaluation and budget purposes, and for an overall understanding of how they are derived. Costs must be based on the terms and conditions of the RFP, including the State's General Provisions and Mandatory Requirements of the RFP (not the Vendor's exceptions to the terms and conditions). The Vendor is required to state all other assumptions upon which its pricing is being determined in the Response Template O – Cost Workbook and Cost Assumptions. Assumptions must not conflict with the RFP terms and conditions including the State's General Provisions or Mandatory Requirements of this RFP.

Vendors are required to provide costs for all phases which must be firm fixed price with payments based on deliverables as proposed by the Vendor. The ongoing Software Maintenance payments must be monthly (based on hours invoiced) for the number and type of Vendor Software Maintenance staff positions to be specified by the Vendor throughout the Contract period. The Vendor must provide fixed Hourly Rates to the State for work to be performed during each phase separately from work to be performed during the Software Maintenance period. In addition, fixed Labor rates must be available for the State to use for Unanticipated Tasks as necessary. The Vendor is required to provide costs for Packaged Software and Hardware. The Vendor must provide costs for the DDI Hosting and Disaster Recovery Services.

Contact Center Services

The ongoing Services payments and any other potential ongoing payments must be monthly based on units proposed by the Vendor (e.g., such measures as number and type of Vendor staff

positions, transaction volumes, population base, hosting and support, etc.) to be specified by the Vendor.

If relevant, the Vendor must provide fixed Hourly Rates to the State for work to be performed. In addition, fixed Labor rates must be available for the State to use for Unanticipated Tasks as necessary.

2.10.2 Proposal Crosswalk — Mandatory Templates

The table below lists the Mandatory templates that the Vendor will submit as part of its Technical and Cost Proposal Packages. The Vendor should decide if it will propose a MMIS response, a Contact Center response, or a response that integrates both a MMIS response and Contact Center response and provide the templates noted in each column according to their response type.

Table 9. Mandatory Response Templates

RESPONSE TEMPLATE	TEMPLATE / ATTACHMENT ELEMENTS	TEMPLATES REQUIRED		
		MMIS RESPONSE	CONTACT CENTER RESPONSE	INTEGRATED RESPONSE
Response Template A	Cover Letter and Executive Summary	X	X	X
Response Template B	Vendor Experience	X	X	X
Response Template C	Vendor References	X	X	X
Response Template D	Subcontractor Letters	X	X	X
Response Template E	Project Organization and Staffing	X	X	X
Response Template F	Staff Experience	X	X	X
Response Template G.1	Response to MMIS Functional System Requirements	X		X

RESPONSE TEMPLATE	TEMPLATE / ATTACHMENT ELEMENTS	TEMPLATES REQUIRED		
		MMIS RESPONSE	CONTACT CENTER RESPONSE	INTEGRATED RESPONSE
Response Template G.2	Response to MMIS Functional Service Requirements	X		X
Response Template G.3	Response to Contact Center Functional Requirements		X	X
Response Template H.1	Response to MMIS Functional Requirements Approach	X		X
Response Template H.2	Response to MMIS Services Requirements Approach	X		X
Response Template H.3	Response to Contact Center Requirements Approach		X	X
Response Template I	Response to Non-Functional Requirements	X	X	X
Response Template J	Response to Technical Requirements Approach	X	X	X
Response Template K	Response to Implementation Requirements Approach	X	X	X
Response Template L	Response to Maintenance Requirements Approach	X	X	X
Response Template M	Work Plan	X	X	X
Response Template N	RFP Response Checklist	X	X	X
Response Template O	Cost Workbook	X	X	X
Response Template Q	Terms & Conditions of this RFP and Any Resulting Contract	X	X	X

2.10.3 Procurement Library

The following table describes the documents that are available in the Procurement Library for reference purposes.

Table 10. Procurement Library

PROCUREMENT LIBRARY ITEM FILE NAME	LIBRARY DOCUMENT TITLE / DESCRIPTION
AHS Medicaid Enterprise Analysis.pdf	Medicaid Enterprise Architecture Analysis (March 2011)
AHS Organization Chart.pdf	Vermont AHS Organization Chart
DMH Billing Enrollment Workflow V7.pdf	Community Rehabilitation Treatment (CRT) Billing & Enrollment Workflow
HSE Platform Reuse Guidance for MMIS v1.pdf	Health Services Enterprise Platform Reuse Guide (MMIS) (June 2014)
HSE VEAF HSEP Strategy and Overview Level 0 FINAL.pdf	Health Service Enterprise (HSE) Vermont Enterprise Architecture Framework (VEAF) Health Services Enterprise Platform (HSEP) Overview and Strategies (April 2014)
Medicaid Operations Business Process Analysis.pdf	Vermont Medicaid MMIS Desired Business Process Analysis (January 2014)
Medicaid Operations IT Procurement GSD.pdf	Medicaid Generalized Systems Design for Medicaid Procurements (October 2013)
MMIS Architecture.pdf	Current Vermont MMIS Architecture
MMIS Report Distribution List.xlsx	Current MMIS Report Distribution List (December 2013)
MMIS Report Output List.xlsx	Current MMIS Report Output List (December 2013)
VT Universal License Agreements.pdf	List of Universal Licenses owned by the State of Vermont

3.0 Overview and Scope of Work

3.1 Overview

The State seeks to procure a Medicaid Management Information System, Technical Support Services and Medicaid Operations Services in support of programs and services that are fully or partially funded by State and Federal Medicaid funds. In addition, the State is consolidating the operations and financial management of non-Medicaid funded programs. As such, the proposed System and Services sought by the State must be expandable and extensible to other programs, services and funding sources. In essence the State is seeking to procure a full SOA based MMIS system, as well as, the associated Fiscal Agent services; except for the Pharmacy

and the Care Management applications and services. The technology and services in scope for this procurement are described below.

In addition, the State intends to consolidate and operate a Vendor-run contact center (Contact Center) that provides Member and Provider services for AHS programs. The Contact Center will require technologies including telephony, Interactive Voice Response System (IVRS) and customer relationship management, as well as Vendor staffing to operate it. As with the MMIS and Medicaid Operations Services, it is necessary for these capabilities to support the changes that the State anticipates in the next 5 to 10 years, including the plan for a transition to universal coverage for all Vermont residents.

The solution including but not limited to the application software, technologies, and services as depicted in this RFP are collectively known as "the System". The procurement, development and operation of these capabilities are collectively known as “the Project”.

3.2 Vermont Process Alignment with MITA 3.0

The State has mapped MITA 3.0 processes to its current and desired business organization and methodology. This is shown as five primary areas (or work streams) and described in the figures below. The MITA - work stream mapping was completed to enhance communications between the Vendor and the State, and to ensure completeness of capabilities. The Vendor is expected to be able to communicate in both the State business orientation and in the MITA construct.

The alignment between the State work streams and MITA is shown by MITA Business Process Area below, as well as three additional classifications: Contractor Management, Other Procurements; and Out-Of-Scope. These classifications are further described later in this document.

Figure 6. MITA Work Stream Map Legend

Figure 7. MITA Business Relationship Management Work Stream Mapping

Figure 8. MITA Care Management Work Stream Mapping

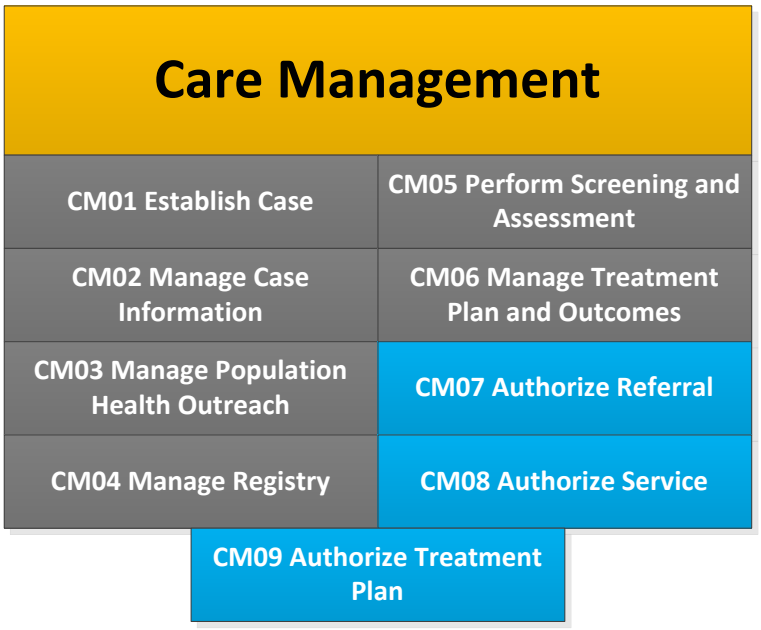


Figure 9. MITA Contractor Management Work Stream Mapping

Figure 10. MITA Eligibility and Enrollment Management Work Stream Mapping

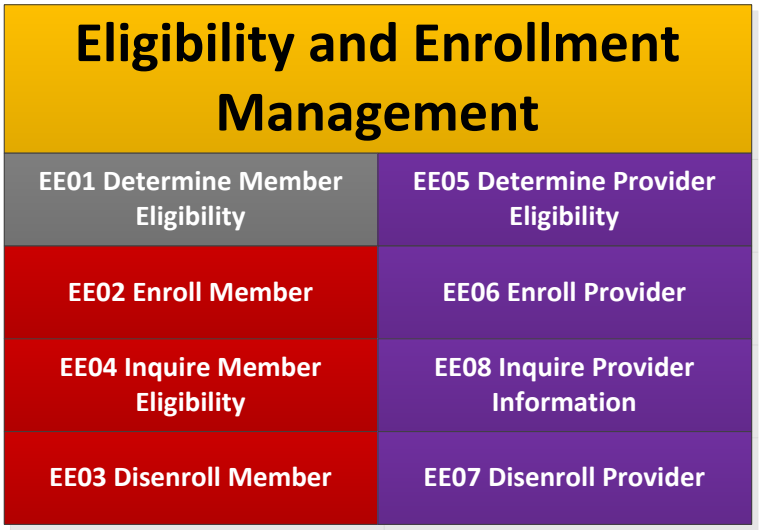


Figure 11. MITA Financial Management Work Stream Mapping

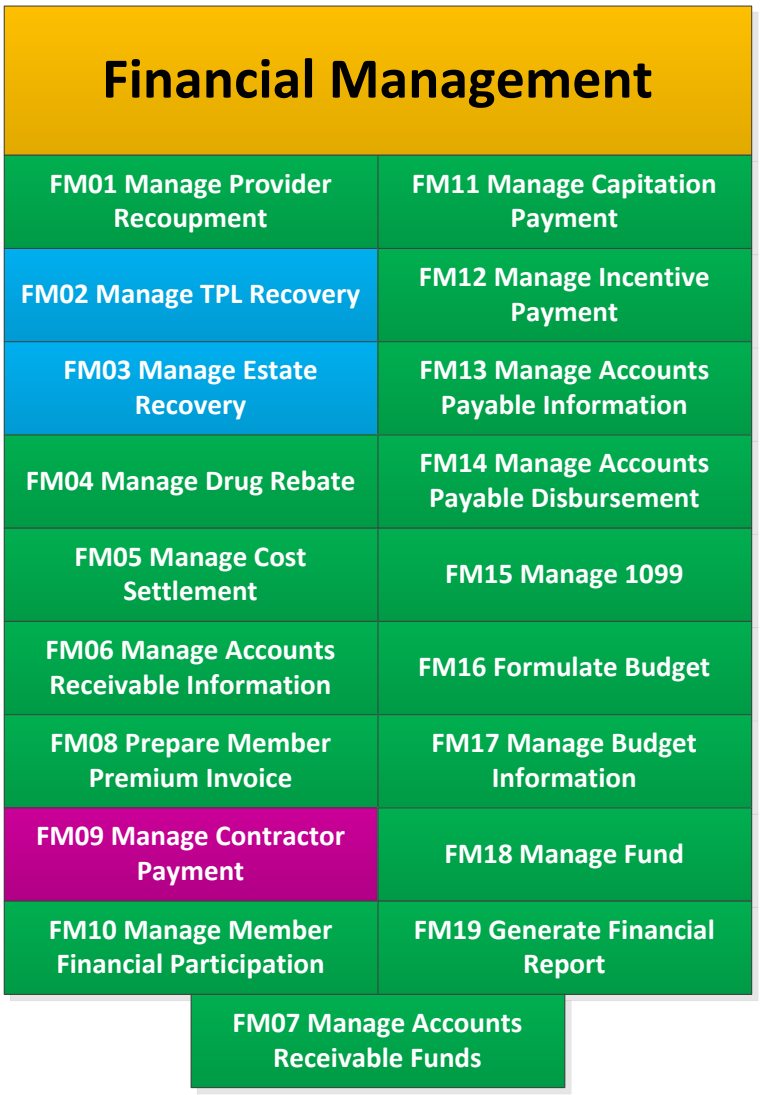


Figure 12. MITA Member Management Work Stream Mapping

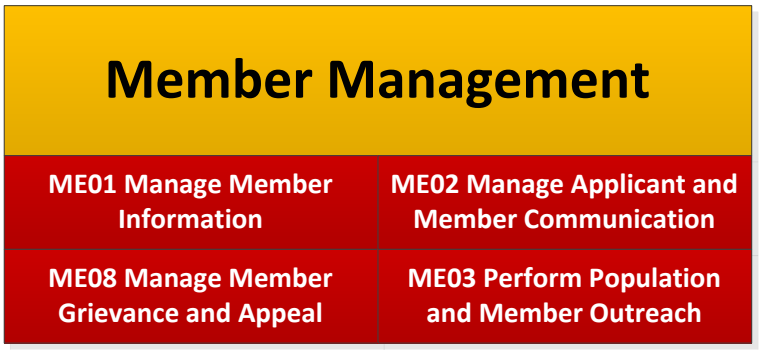


Figure 13. MITA Operations Management Work Stream Mapping

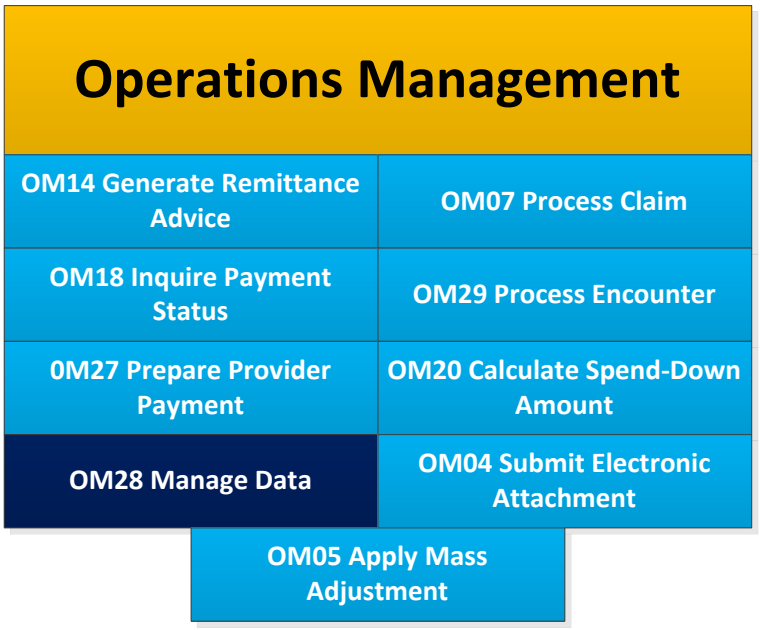


Figure 14. MITA Performance Management Work Stream Mapping

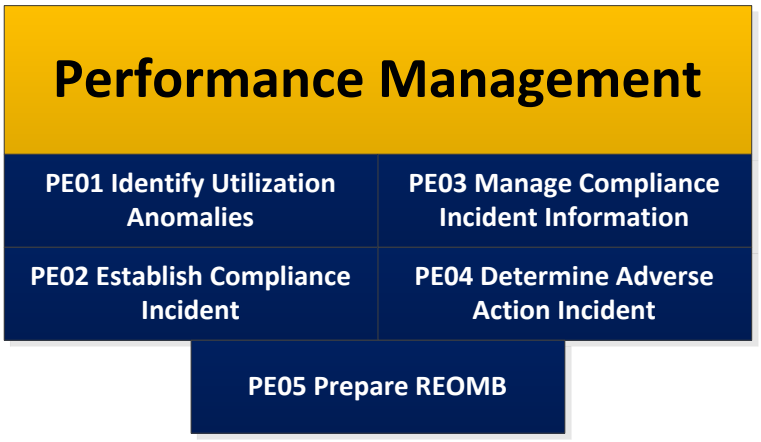
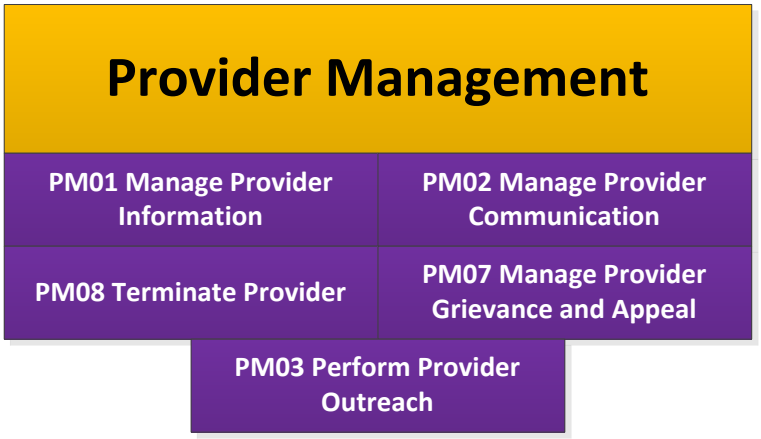


Figure 15. MITA Plan Management Work Stream Mapping

Figure 16. MITA Provider Management Work Stream Mapping



The table below describes the Vermont work streams and the alignment with MITA 3.0. Three additional classifications of the Vermont work streams are also discussed

Table 11. Vermont Work Streams Alignment to MITA Business Processes

WORK STREAM NAME	ALIGNMENT WITH MITA 3.0
Operations Management	Operations Management includes the core operations and associated activities related to accepting, processing, adjudicating and managing claims. The work stream also includes the State's Coordination of Benefits (COB) activities and activities around Third Party Liability (TPL), including but not limited to, estate recovery, casualty recovery, cost-avoidance, annuities and trusts.
Financial Management	Financial Management handles all accounts receivables, accounts payables and budgeting.
Member Services	Member Services is responsible for a member's PCP enrollment, member information, and member communications. A notable exception to this work stream in Vermont is the absence of eligibility determination, which is managed by the State's Department for Children & Families Economic Services Division using the IE (ACCESS) system or its replacement. The work stream also includes the management of Member Fair Hearings, Grievances and Appeals for eligibility determination and covered services
Provider Management	Provider Management is responsible for all provider eligibility, enrollment, disenrollment, and management functions. The work stream also includes the management of Provider Grievances and Appeals.
Data Analytics	Data Analytics is responsible for the overall management of data contained within the MMIS and interfaces with partner systems to

WORK STREAM NAME	ALIGNMENT WITH MITA 3.0
	provide robust data analytics needed for management of programs. This work stream also includes the Program Integrity functions.
Contractor Management	Currently, the State does not have a consolidated Contractor Management function. Vendors are asked to propose their capabilities in this area in Response Template H.1 – Functional Requirements Approach.
Other Procurements	The State has and is in the process of re-procuring capabilities that help to complete the MITA 3.0 model. These procurements are described as related initiatives elsewhere in this document
Out Of Scope	Some Medicaid functions will continue to be managed by other solutions. These other solutions include, but are not limited to: ■ The PBM solution and Vendor provide all PBM capabilities necessary for Medicaid, with the exception of claims payments and some data management. ■ The Care Management system provides several of the functions within the MITA 3.0 Care Management business process area. ■ The State IE system (currently ACCESS; to be replaced by a new system in the near future) and the VHC solution provide eligibility determination for Medicaid The MMIS and the Contact Center solutions must interface with these other solutions.

3.3 Envisioned Medicaid Management Information System and Services Overview

The MMIS and Medicaid Operations Services requested in this RFP include all of the functionality described in the Operations Management, Financial Management, Member Management, Provider Management and Data Analytics workstreams described in the previous section, except as described in the following section, "Envisioned Green Mountain Care Contact Center Overview". The MMIS and the Medicaid Operations Services are expected to provide all but not limited to MITA 3.0 processes except for those provided by another identified system / vendor, and additional capabilities as identified in this RFP. The MITA 3.0 alignment is discussed in a previous section of this RFP and includes at least the State Integrated Eligibility system (currently ACCESS), the Medicaid Pharmacy Benefits Management solution, the Care Management solution, and the Contact Center solution.

3.4 Envisioned Green Mountain Care Contact Center Overview

As part of this effort, the State has consolidated the Medicaid and Vermont Health Connect call center functions into a single Contact Center Solution. The State will further consolidate the Provider Call Center with the Medicaid and Vermont Health Connect Call Center to create a single Contact Center Solution that will provide assistance to Green Mountain Care members and providers. The Contact Center will manage, track and report on services via multiple channels including telephone, Interactive Voice Response System (IVRS), Web portal, email and mail. The Vendor must provide an integrated contact management system to be used in tracking and managing customer contacts from all channels, and that can report on customer contact metrics by channel or comprehensively.

The Vendor is expected to provide high quality interactions with Vermonters. Customer Support Representatives (CSRs) must solve customer problems efficiently and provide accurate, complete and clear information so Vermonters can make well-informed decisions. These goals should be achieved through an engaged dialog that seeks appropriate information from the caller so issues are thoroughly understood before a resolution is initiated or the need for escalation to a Tier 2 entity is required. Interactions should involve conversations that do not rely simply on reading scripts verbatim to callers, although scripts may be used as a resource.

The table below provides a brief description of the Contact Center functions by workstream.

Table 12. Contact Center Function By Workstream

WORK STREAM NAME	ALIGNMENT WITH MITA 3.0
Member Services	Contact Center Member Services is responsible for Tier 1 member-facing

WORK STREAM NAME	ALIGNMENT WITH MITA 3.0
	enrollment, disenrollment, member information request, and member communication support. This includes outreach, education and outgoing mailing support. Details of these functions and technology are provided later in this document.
Provider Management	Contact Center Provider Management is responsible for all provider eligibility, enrollment, disenrollment, and the management of the services functions using the MMIS and a Contact Center-provided CRM solution. Details of these functions and technology are provided later in this document.

3.5 Project Overview

The MMIS, Medicaid Operations Services and Contact Center system and services will replace the current technologies (except for those of the evolving HSE Platform) and services in place to support the Vermont Medicaid enterprise and AHS as a whole. This Project also adds further capabilities and flexibility to allow for ongoing enhancements to the way that Vermont provides health and human services to its residents.

3.5.1 Programs Covered

DVHA serves through agreement with AHS as the Public Managed Care Organization for all enrollees under Vermont's Global Commitment to Health Waiver. Because of the agreements (which may include Inter-governmental Agreements [IGAs] or Memoranda Of Understanding [MOUs]) between AHS and DVHA, and the subsequent agreements between DVHA and other departments within AHS, as well as with the Agency of Education, actual administration of the program is quite broad and occurs within all of the departments that expend Medicaid dollars. DVHA administers the Medicaid program through agreements with the following departments:

- Department for Children and Families (DCF)
- Vermont Department of Health (VDH)
- Department of Disabilities; Aging and Independent Living (DAIL)

- Department of Mental Health (DMH)
- Department of Corrections (DOC)
- Agency of Education

Roughly 50 percent of Medicaid funds are administered through programs in departments other than DVHA. These include, but are not limited to: behavioral and mental health services; skilled nursing services for children and families; services for individuals with developmental disabilities, serious and persistent mental illness; substance abuse services; and EPSDT administrative claims processing services.

3.5.2 Project Objectives and Goals

The State has identified several business drivers for the procurement of a contemporary MMIS, Medicaid Operations Services and Contact Center. These drivers include:

- **Improve the customer service provided to Vermonters and Medicaid providers**. Vermonters serviced by VT Medicaid should expect prompt, professional and efficient services. Medical providers should expect Vermont Medicaid to provide exceptional services and quality.
- **Contract limitations and cost to maintain / change the system.** The existing system requires an excessive amount of human support to maintain and change functionality. These changes are costly to make and are not able to be performed quickly enough. The State expects that the new solutions(s) will be configurable by Vermont business users as much as possible to allow for timely and cost-effective updates.
- **Support of the State's vision of an Agency of One, supporting additional programs in the primary benefits management and claiming systems.** Currently, it is complex and time consuming to address changes in Medicaid programs and to manage partially or non-Medicaid funded programs. The new solution(s) must allow business users to manage definition and changes to programs. (See Section 1.6.6 for additional details on the Agency of One vision)
- **Improve efficiency and effectiveness of Medicaid Operations by increasing AHS' MITA 3.0 maturity**. AHS would like to improve the use of technology by using automation and electronic communications where possible. The proposed solution should provide the maximum use of these advanced tools and processes where possible and reasonable while providing continued service to all Vermonters, regardless of their technology capabilities.
- **Need for more effective cost avoidance and cost recovery through maximizing, fraud, waste and abuse prevention / detection capabilities.** The State requires capabilities for

proactive prevention / detection and retroactive Fraud, Waste and Abuse capabilities to detect and recapture inappropriate payments.

- **Support of Vermont's transition to a universal health system for all Vermonters, assuring access to and coverage for high-quality health care to all Vermont residents.** Act 48 has laid the foundation for the State to transition to universal publicly-financed coverage for all Vermont residents. The proposed solution(s) must support the State's ability to make this transition and continue to provide, at minimum, Medicaid enterprise support in the new State payer structure.

- **Need to support multiple, evolving payment models.** The State is expanding and testing a number of contemporary payment methodologies as part of the SIM initiative. The new solution(s) must be able to manage these, and other advanced payment models. Current envisioned models include:

  - Population-based Performance: Vermont Shared Savings ACO Models — a system of integrated delivery and financing for Medicaid patients through an organized network of participating Providers who have agreed to align their clinical and financial goals and incentives to improve quality of care and reduce cost. Under a three-year program starting 1/1/2014, DVHA will make lump sum "savings" payments to ACOs that achieve certain financial and quality benchmarks on an annual basis. Payments would be distributed seven (7) to eight (8) months following the end of a performance year.

  - Coordination-based Performance: Bundled Payment Models — replace FFS incentives with those that reward collaboration and evidence-based practices across specialties and PCPs for targeted episodes of care, which represent opportunities for high return on investment.

  - Individual-based Performance: Pay for Performance (P4P) Models — enable all payers, particularly Medicaid, to use second generation P4P purchasing strategies to improve performance and quality of its health systems. A program is in development to pay incentives to Providers who meet certain financial or quality performance benchmarks. The mechanism could vary and be on a per-member-per-month (PMPM) basis; monthly, quarterly or annual lump sum basis; or added to claims-based transactions.

  - Capitation: DVHA is considering making capitated payments to organizations (like ACOs) for sets of services, rather than paying FFS claims. Under this arrangement, Providers would likely continue to bill encounter claims to the MMIS for data collection, monitoring and evaluation, risk adjustment, capitation rate recalibration, and PI efforts, among others. Payments will be processed through a different

mechanism, however, and could be on a PMPM basis, monthly, quarterly or annual lump sum basis.

- **Need to move beyond silos to an integrated enterprise that support improved customer experience and integrated services.** The State has invested in technologies that can serve more than one purpose and specifically in those that can provide shared technology services to support the model of the HSE. The new solutions(s) must build on and consume those services that currently exist or are planned.

- **Mandates to comply with all regulatory reporting and service delivery requirements.** The State requires a MMIS that will support new and evolving reporting and service delivery requirements in the Medicaid, health care and payer landscapes.

The State wishes to receive a broad set of innovative responses that will position it for a rapidly changing environment but which will still provide a low risk approach to more rapid development and deployment of an MMIS than has been the norm in the industry. Vendors are encouraged to provide the solution that will best help achieve the needs and goals and requirements as stated in the RFP, including the extensibility and adaptability necessary to support the State's envisioned transition to universal health coverage, GMC 2017.

3.6 Project Approach

The State intends to award one (1) or two (2) Contract(s) to one or two prime Vendor(s) and any subcontractors to these prime Vendors to provide the following Components to the State. All else being equal, it is the State's preference to award a single contract for both, however the State will consider awarding separate contracts for each of:

- MMIS, technology support and Medicaid Operations Services

- Contact Center systems and services

The State is interested in proposals that demonstrate an integrated team approach with a single prime Vendor for each or both of the Components.

Through its response to this RFP, the responding Vendor must demonstrate an approach and solution that will provide a flexible and interoperable MMIS and/or Contact Center that will fit within the vision for the State's enterprise approach to technology for Vermont's health and human services programs.

The Vendor(s) shall provide application configuration and implementation services for the components that they are awarded. The MMIS Vendor shall also provide Medicaid Operations Services, infrastructure support and management, as well as application maintenance and operations (M&O) in production.

3.7 Proposed MMIS Solution and Services

The MMIS Solution will consist of a technology solution, M&O and Medicaid Operations Services.

- The technology System and Services will achieve the following:
  - Provide functional support for the Vermont Medicaid enterprise, with the capability to expand to additional services as described in this document
  - Comply with CMS' Seven Conditions and Standards and MITA 3.0
  - Leverage, to every extent possible, the State of Vermont HSE Platform technologies and standards
  - Attain certification by CMS for the MMIS
  - Support annual State Self-Assessment reviews
  - Interface with Federal and State partner systems to ensure that all necessary data flows from the MMIS to the relevant systems, and that relevant data required for service validation, payment, and other reporting and analysis flows from Federal and State systems to the MMIS
  - Operate and maintain the technology implemented
- The Services that will be provided by the Vendor will include the following:
  - Interface with the State eligibility operations to ensure that eligible Members are appropriately enrolled
  - Develop, manage, and provide support to the Provider network
  - Process all claims and prepare claims for payment, in coordination with other systems
  - Issue relevant and valid payments
  - Maintain financial data for all programs managed through the MMIS as the auditable Fiscal Agent entity for Medicaid
  - Conduct and produce necessary and required data analytics and reporting

The State has separated the MMIS Services into five (5) work streams as described in other sections of this document. The following sections describe the Functional Requirements and Non-Functional Requirements for the technology and services required of the MMIS. Functional

Requirements are defined as how the System needs to behave in order to support the business functions. Non-Functional Requirements are derived from the nature of the System the State anticipates implementing to meet the Functional Requirements and includes requirements in the following categories:

- Requirements that are identified for each individual business activity but apply to a very wide variety of such activities (e.g., System performance and usability requirements)
- Requirements that define how systems should be designed and built to anticipate future changes and related standards (e.g., alignment with the State's architecture, adopted standards including MITA 3.0 and CMS' Seven Conditions and Standards)
- The State's requirements for how systems and services are designed, implemented and supported

3.7.1 Summary of Functional Requirements

The following outlines the functional requirements that the Vendor's proposed technology must deliver. High-level business process descriptions can be found in the Procurement Library and detailed requirements are found in Response Template G.1 – Functional System Requirements. The Vendor will respond to the Functional Requirements and its approach to meeting them in Response Templates G.1 and H.1.

3.7.1.1 Member Services

The State of Vermont's goal is to provide members with an outstanding customer experience. The Member Services functionality supports the ability to capture, manage, and maintain information for the State's prospective or enrolled Members and support the enrollment business processes. Functionality also supports the business processes involved in communications between the State and the prospective or enrolled Members. Communication management functions include, but are not limited to: Member correspondence and notifications, outreach and education, and Member Fair Hearing, Appeal and Grievance tracking.

The Member Services capabilities requested in this RFP are largely in line with two (2) MITA 3.0 Business Areas: Eligibility and Enrollment (EE) and Member Management (ME). The specific processes are outlined in the following table.

Table 13. Vermont Alignment with MITA 3.0 Member Services Business Process Area

MITA 3.0 PROCESS NUMBER	MITA 3.0 PROCESS NAME
Eligibility and Enrollment	

MITA 3.0 PROCESS NUMBER	MITA 3.0 PROCESS NAME
EE02	Enroll Member
EE03	Disenroll Member
EE04	Inquire Member Eligibility
Member Management	
ME01	Manage Member Information
ME02	Manage Member Communication
ME03	Perform Population and Member Outreach
ME08	Manage Member Grievance and Appeal

Functionality

The Member Services System capabilities include, but are not limited to:

- **Member Information / Reporting:** Provide authorized users the ability to easily query the Member data to retrieve information including, but not limited to: basic demographic data, historical program eligibility data, TPL data and benefit data. Authorized users may also access, view, edit and manage Member data, and perform Member-related tasks.
- **Member Communications and Outreach:** Authorized Members shall have the ability to access information through an online portal and perform basic management actions such as updating Member information.

Member Fair Hearing, Grievances and Appeals for eligibility determination and covered services are in scope for this procurement and the MMIS must provide the ability to record that a claim, enrollment or other transaction is under appeal, whether the transaction and subsequent transactions should be processed pending an appeal decision, and lastly, to record the appeal outcome.

3.7.1.2 *Provider Management*

The Provider Management functionality provides the ability to capture, manage, and maintain information for the State's prospective or enrolled Providers and support the enrollment business processes. This area also supports the business processes involved in communications between the State and the prospective or enrolled Providers. Communication management functions include, but are not limited to: Provider correspondence and notifications, outreach and education, and Provider appeal management and tracking.

The Provider Management capabilities requested in this RFP are largely in line with two (2) MITA 3.0 Business Areas: Eligibility and Enrollment (EE) and Provider Management (PM). The specific processes are outlined in the following table.

Table 14. Vermont Alignment with MITA 3.0 Provider Management Business Process Area

MITA 3.0 PROCESS NUMBER	MITA 3.0 PROCESS NAME
Eligibility and Enrollment	
EE05	Determine Provider Eligibility
EE06	Enroll Provider
EE07	Disenroll Provider
EE08	Inquire Provider Information
Provider Management	
PM01	Manage Provider Information
PM02	Manage Provider Communication
PM03	Perform Provider Outreach
PM07	Manage Provider Grievance and Appeal

Functionality

The Provider Management System capabilities include, but are not limited to:

- **Provider Portal:** Establish a Provider portal to enable submission, maintenance and inquiry of key information, including a method of addressing the multiple existing and planned Provider Portals.
- **Provider Enrollment:** Determine a Provider's eligibility, verify licensing/credentialing, enroll to provide specific services or benefits, manage aggregation of Providers in flexible groupings for evolving payment strategies (including ACO, Shared Savings, etc.), and process disenrollments when appropriate. In some cases, enrollment will include navigating the complexity of multiple provider numbers for the same person / entity.
- **Provider Information Management:** Maintain Provider-specific information and provide authorized users access to inquire, view and edit the information.
- **Provider Grievance and Appeals:** Capture all actions and milestones related to the filing and hearing of Provider appeals and grievances.
- **Provider Submission of Electronic Financial Detail:** Providers who are receiving case rate, sub-capitated or other non-fee for service payments for specialty programs, such as those serving persons with developmental disabilities, severe and persistent mental illness, traumatic brain injury and other vulnerable populations, are expected to deliver electronic financial information to the state. The state provider level financial information is used to monitor aggregate annual caps, track budget to actual variances and negotiate rate adjustments with certain state designated providers.

3.7.1.3 Operations Management

The Operations Management functionality supports the activities required to establish benefits, authorize medical activities, process claims for payment and adjust claims after the fact. This includes, but is not limited to:

- The receipt and adjudication of Provider claims to generate the appropriate disposition;
- Apply mass adjustments to previously adjudicated claims and all activities related to recovering funds that are determined to be overpaid due to third party liabilities;
- Detail the plan(s), benefit(s), and rate information that must be created and maintained within the MMIS in order to successfully adjudicate the claims; and
- Receive the request for a prior authorization for a referral, service, or planned encounters (via a treatment plan). The processes also track the authorization status and the information that must be referenced when processing the claim for the pre-authorized action.

The Operations Management capabilities requested in this RFP are largely in line with three (3) MITA 3.0 Business Areas: Operations Management (OM), Care Management (CM), and Plan Management (PL). In addition, this includes any third party recovery activities that are categorized as Financial Management within the MITA 3.0 framework. The specific processes are outlined in the following table.

Specific to Coordination of Benefits and the "pay-and-chase" process, the Vendor will provide support to recover payments to ensure Medicaid is the payer of last resort. The State is in the process of developing workflows for these activities and will provide them to the winning vendor at the beginning of DDI. The activities and the entities responsible for these activities include but are not limited to:

- Casualty Recovery – The Vendor will initiate the process and the State will complete the process
- Estate Recovery – The Vendor will collect payments and will manage the associated accounts receivable
- Health Insurance Premium Program (HIPP) – The State will initiate the process and the Vendor will complete the process
- Health Insurance Recovery – The State and the Vendor will work collaboratively on this process
- Medicare Prescription Drug Program (PDP) – The State and the Vendor will work collaboratively on this process
- Nursing Home, Credit Balance and Patient Share – The State and the Vendor will work collaboratively on this process
- Trust and Annuity Accounts – The Vendor will collect payments and will manage the associated accounts receivable
- Third Party Liability (TPL) and Medicare Cost Avoidance – The State and the Vendor will work collaboratively on this process
- Billing and Claims processing – The State and the Vendor will work collaboratively on this process
- Data Matching – The State and the Vendor will work collaboratively on this process
- Explanation of Benefits (EOB) – The Vendor will support the State in this process

Table 15. Vermont Alignment with MITA 3.0 Operations Management Business Process Area

MITA 3.0 PROCESS NUMBER	MITA 3.0 PROCESS NAME
Operations Management	

MITA 3.0 PROCESS NUMBER	MITA 3.0 PROCESS NAME
OM04	Submit Electronic Attachment
OM05	Apply Mass Adjustment
OM07	Process Claims
OM14	Generate Remittance Advice
OM18	Inquire Payment Status
OM20	Calculate Spend-Down Amount
OM27	Prepare Provider Payment
OM29	Process Encounters
Care Management	
CM07	Authorize Referral
CM08	Authorize Service
CM09	Authorize Treatment Plan
Financial Management	
FM02	Manage TPL Recovery
Plan Management	
PL04	Manage Health Plan Information
PL05	Manage Performance Measures

MITA 3.0 PROCESS NUMBER	MITA 3.0 PROCESS NAME
PL06	Manage Health Benefit Information
PL07	Manage Reference Information
PL08	Manage Rate Setting

A number of additional business process areas are included in the Operations Management work stream. The MITA 3.0 process areas and the reason for their inclusion or exclusion in this work stream are outlined below.

Table 16. Additional MITA 3.0 defined Operations Management Business Process Areas

MITA 3.0 PROCESS NUMBER	MITA 3.0 PROCESS NAME	VERMONT REASON FOR INCLUSION / EXCLUSION
FM02/FM03	Manage TPL Recovery Manage Estate Recovery	All TPL recovery activities are managed in the Vermont Medicaid enterprise by the COB Unit of the DVHA and are considered one (1) business process. For this reason, FM03 (Manage Estate Recovery) has been merged with FM02 and covered within the Operations Management section.

MITA 3.0 PROCESS NUMBER	MITA 3.0 PROCESS NAME	VERMONT REASON FOR INCLUSION / EXCLUSION
CM01 - CM06	Care Management	The State of Vermont is implementing a Care Management system independent of the MMIS. As a result, the MMIS does not need to support these processes though it must interface with the Care Management system in support of operations, activities and processing of authorizations independent of the Care Management system.
OM, PM	Operations Management, Plan Management	All pharmacy benefits activities will be supported by the PBM solution with a few exceptions (e.g., PL04, Manage Health Plan Information). As such, the Operations Management processes do not need to support the processing of Pharmacy information.
OM28	Manage Data	This process is covered within the Data Analytics work stream.

The State has compared its processes and business environment (both current and future) to MITA 3.0 and found that there are some redundancies as follows:

- The process and requirements to support OM07 (Process Claims) and OM29 (Process Encounters) are very similar
- The process and requirements to support CM07 (Authorize Referral), CM08 (Authorize Service), CM09 (Authorize Treatment Plan) are very similar
- FM03 (Manage Estate Recovery) is not a separate process but a sub-process, with unique steps and requirements, of FM02 (Manage TPL Recovery). In this regard, the VPHARM and HIPP processes are TPL Recovery sub-processes.

The discussions of the above processes have been merged, where appropriate, to avoid duplication, add clarity and better describe the State's environment / requirements.

Functionality

The Operations Management System capabilities will include, but are not limited to:

- **Plan Tracking and Reporting:** Provide the data and reports required to analyze potential Benefits Plan changes and measure plan performance, as well as manage and update reference information.
- **Care Management:** Support approval and tracking of services.
- **Claims Processing and Adjudication:** Support the receipt of claims/encounters through a variety of means (e.g., electronic file submission, Web portal, paper, triggered within the MMIS, electronically from the PBM system); integrate with the IE system to confirm and update eligibility status; process and adjudicate claims/encounters received and prepare them for payment, associating claims with Provider groupings associated with established payment methodologies, and associating service information to the claim and Provider; provide self-service capabilities through a Web portal (e.g., allowing Providers to check status of a claim); support the auditing and processing of "Incident To" claims; and support all activities related to mass-adjustments to claims that have already been processed and paid.
- **Coordination of Benefits and Third-Party Liability:** Support all analysis related to third party liability to identify recovery opportunities and track all TPL case related activities.

3.7.1.4 Financial Management

Financial Management functionality supports the ability to manage the financial services across State organizations and to manage multiple funds. The MMIS will be the core financial management System for all Medicaid-funded programs in Vermont, and ultimately the financial solution for other Human Services programs. The System will also need to be extensible to manage additional funds and programs as needed. There are currently a number of programs that are funded using state, federal or a blending of funding sources with claims and/or payments processed through the current MMIS. In the future, Vermont's move to Green Mountain Care will increase coordination necessary among funding and coverage sources in a manner that is invisible to the Vermonter.

The Financial Management capabilities requested in this RFP are largely in line with one (1) MITA 3.0 Business Area: Financial Management (FM). The specific processes are outlined in the following table.

Table 17. Vermont Alignment with MITA 3.0 Financial Management Business Process Area

MITA 3.0 PROCESS NUMBER	MITA 3.0 PROCESS NAME
Financial Management	

MITA 3.0 PROCESS NUMBER	MITA 3.0 PROCESS NAME
FM01	Manage Provider Recoupment
FM05	Manage Cost Settlement
FM06	Manage Accounts Receivable Information
FM07	Manage Accounts Receivable Collection/Refund
FM08	Prepare Member Premium Invoice
FM10	Manage Member Financial Participation
FM11	Manage Capitation Payment
FM12	Manage Incentive Payment
FM13	Manage Accounts Payable Information
FM14	Manage Accounts Payable Disbursement
FM15	Manage 1099
FM16	Formulate Budget
FM17	Manage Budget Information
FM18	Manage Contractor Payment
FM19	Generate Financial Report

A number of additional business process areas that are defined within the MITA 3.0 Financial Management category are not included in this work stream. The MITA 3.0 process areas and the reason for their inclusion or exclusion in this work stream are outlined below.

Table 18. Deviation from MITA 3.0 Financial Management Business Process Area

MITA 3.0 PROCESS NUMBER	MITA 3.0 PROCESS NAME	VERMONT REASON FOR INCLUSION / EXCLUSION
FM02	Manage TPL Recovery	The COB unit of the DVHA manages TPL recovery in the Vermont Medicaid enterprise. These processes are covered under the Operations Management work stream.
FM03	Manage Estate Recovery	The COB unit of the DVHA manages Enterprise recovery in the Vermont Medicaid enterprise. This process is covered under the Operations Management work stream.
FM04	Manage Drug Rebate	In Vermont, the PBM unit of the DVHA manages all PBM functions. All technical capabilities and services are managed by a PBM contract. The MMIS will be responsible for accepting data from the PBM system for reporting and for payment of pharmacy providers.
FM09	Manage Contractor Payment	Contractor Management is managed in its entirety in another area of this RFP.

Functionality

The Financial Management System capabilities include, but are not limited to:

- **Accounts Receivable:** Track Accounts Receivables and post payments against outstanding A/R's; recoup past payments against the original claim and funding source; support of Member financial participation (payments received from Members); and include Provider taxes and other specialized payments (e.g., Success Beyond Six).

- **Accounts Payable:** Support of calculating and processing multiple payment types (capitation, bundled, one-time or recurring lump sum, shared savings ACO, pay-for-performance, manual, etc.); manage Accounts Payable by funding source; support of Member financial participation (payments relating to other payers) including Medicare / commercial buy-in and clawback.

- **Incentive Payments:** Manage qualification, certification and validation of eligibility for proactive and retroactive payments, and support of Provider, payer and Member incentives.

- **Penalties:** Manage determination and processing of performance-based and other proactive and retroactive penalties for Providers.

- **Budgeting:** Retrospective review/comparison of budgets, initiatives, and funds, and prospective planning for budgeting, Financial Budgeting Report (FBR), scenario and "what if" analyses.

- **Reporting and Document Generation:** 1099 management and generation; Federal, State and Agency reporting; and acceptance and feeds from/to other State systems for appropriate transaction posting and reporting.

3.7.1.5 Data Analytics

The Data Analytics capabilities requested in this RFP are largely in line with three (3) MITA 3.0 Business Areas: Operations Management (OM), Performance Management (PE) and Provider Management (PM). The specific processes are outlined in the following table.

Table 19. Vermont Alignment with MITA 3.0 Data Analytics Management Business Process Area

MITA 3.0 PROCESS NUMBER	MITA 3.0 PROCESS NAME
Operations Management	

MITA 3.0 PROCESS NUMBER	MITA 3.0 PROCESS NAME
OM28	Manage Data
Performance Management	
PE01	Identify Utilization Anomalies
PE02	Establish Compliance Incident
PE03	Manage Compliance Incident Information
PE04	Determine Adverse Action Incident
PE05	Prepare EOB
PM07	Manage Provider Grievance and Appeal

The Data Analytics work stream includes consideration of reporting and analytics across all processes, data and aspects of the MMIS across all work streams. Data Analytics also includes all of the highly specialized analytics and case tracking needs for Program Integrity and Provider Compliance.

There are four key sets of capabilities required in this work stream:

- General Reporting and Analytics
- Program Integrity
- Provider Compliance Tracking
- Interfaces with External Systems and Storage of Data for Enhanced Analytics

General Reporting and Analytics

In order to measure and address key performance objectives, satisfy internal and external information requests and comply with mandates for State and Federal reporting, the State

requires a MMIS with well integrated capabilities that provide simple and efficient access to all MMIS data including claims, encounter, Provider, and Member details. The detailed requirements (included in Response Template G.1 – Functional System Requirements) include a wide variety of predefined standard reports and dashboards.

In addition, the State requires the ability to quickly and easily extend the level and detail of information available. This will include the deployment of Business Intelligence and Reporting tools that enable:

- Speedy development of additional reports, dashboards and analytical models
- Self-service capabilities that allow end-users to:
  - Run a variety of prebuilt standard/parameterized reports and dashboards
  - Interactively query and drill into data and create reports and dashboards
  - Interactively model a variety of patterns, trends, scenarios and outcomes using prebuilt modeling and data mining applications
  - Administer and manage the library of reporting and analytics assets

The MMIS will offer a broad set of reporting and analytics capabilities. Using these and achieving maximum benefit may be difficult and bewildering to users. The State therefore needs strong and focused support in the following areas:

- Identify, prioritize and plan additional analytics capabilities needed
- Collaborate with the State to define requirements, acquire and implement such capabilities
- Help desk support for use of tools and techniques, as needed
- Development of the State's analytics staff skills and knowledge

Program Integrity

The Data Analytics work stream includes a specialized System with associated services to support all aspects of the Program Integrity process including surveillance, investigations and case tracking.

The State is looking to enhance current capabilities through the adoption of industry best practices to allow the State's Program Integrity function to:

- Identify fraud, waste, abuse through improved detection methods resulting in more timely, improved issue identification and recovery of funds
- Achieve quicker, broader and deeper intelligence identifying patterns of utilization, claiming and payment that differ from best practice and the norm
- Investigate and reveal abuse of the State's Medicaid program and promote corrective action
- Support efforts to maximize the effective utilization of Federal, State and local funds

To meet these Program Integrity improvements, the State needs system and service support that address a single, consistent and extensible set of Medicaid analytics for Fraud, Waste and Abuse, that incorporate data from multiple sources, and that utilize data management tools that provide the ability to easily access, analyze and share information directly from the user's desktop.

The Program Integrity solution must be highly integrated from a user perspective, providing focused reporting and analytics self-service for a variety of roles, including Auditors and Quantitative Analysts, with easy point-and-click query construction for the users, from the novice to the technically sophisticated.

The solution must include Vendor provided staff who will, through the analysis of MMIS claims and other data, identify patterns of abnormal Provider and Member activity and identify possible fraud, waste and abuse activity. They will deliver these through Provider reports and report cards, utilization reports, and monthly operational reports.

To maximize the benefits obtained from the analytics services provided, the System must directly support close collaboration between the Vendor's analytics support staff and State Auditors and Quantitative Analysts. The Vendor will also provide Knowledge Transfer including systems use and analytics techniques education to State Auditors and Data and Financial Analysts.

The State requires that this requirement must be provided by a Vendor that has a substantial successful track record of delivering and operating technology, systems and specialized services that support Medicaid Program Integrity. To this end, the State requires that the Vendor propose one Program Integrity solution, but will allow the Vendor to propose additional alternative industry-leading solutions and / or subcontractors that can deliver Program Integrity support.

Regardless of the number of Program Integrity solutions proposed, the State, at its discretion, will evaluate and score the Program Integrity solutions based on their individual merits and costs, and in the context of the overall MMIS proposal to achieve the maximum benefit and value for the State.

Provider Compliance Tracking

In order to efficiently manage Provider Compliance, the State requires a set of Provider Compliance reporting and integrated case tracking capabilities to manage identified anomalies and resultant corrective actions.

Scope of Data and Source Systems for Enhanced Analytics

The MMIS Data Analytics System capabilities will provide the functionality described below based on an integrated set of data that comprises:

- Any of the MMIS operational data (both current and archived)
- Data extracted from a number of AHS Systems used to manage the health services provided by government funding in VT. These systems include, but are not limited to, the following:
  - Vermont Department of Health (VDH)
    - Ladies First Program – Breast and Cervical Care Tracking System HIV/AIDS Support – Vermont Medication Assistance Program – VMA System
    - Early Periodic Screening Diagnosis and Treatment (EPSDT) Tracking System
    - Maternal and Children's Health – Children with Special Health Needs (CSHN) System
  - Department of Disabilities, Aging and Independent Living (DAIL)
    - Social Assistance Management System (SAMS)
  - Department of Mental Health (DMH)
    - Critical Incident Tracking System (also used by the Department of Disabilities, Aging and Independent Living)
  - Department of Children and Families (DCF)
    - Child Development Division – Bright Futures Program (subsidized child care) – Bright Futures Information System (BFIS)
    - Child Development Division – Early Intervention System

- Family Services Division (FSD) – Child Welfare System – FSDNET
- Family Services Division (FSD) – Foster Care – Social Services Management Information System (SSMIS)

Functionality

The Data Analytics System capabilities will include, but are not limited to:

- **Reporting and Analytics Information Delivery:** Standard reports; exception reports; dashboards; ad-hoc queries; online analytical processing (OLAP) cubes; and integration with personal productivity tools.
- **Mathematical and Statistical Functions and Modeling:** Scenario/what-if analyses; trend analyses; data mining; interactive discovery; and visualizations.

3.7.2 Summary of Medicaid Operations Services Requirements

The Vendor will be responsible for providing Medicaid Operations Services for the SMA and will be the auditable source for all financial transactions that it processes. The following outlines the core services expected from the Vendor. Detailed Service requirements are found in Response Template G.2 – Functional Service Requirements. These capture the Services the Vendor will provide in performing the business processes for the State after the System goes live. The execution of these activities will be governed by the Service Level Requirements (SLR) outlined in other sections of this document. These are in addition to the System M&O processes and activities outlined within the Non-Functional Requirements.

The Vendor will respond to the Service requirements and its approach to meeting them in Response Template G.2 – Functional Service Requirements and Response Template H.2 – Services Requirements Approach.

3.7.2.1 General Services

The General Services to be provided include, but are not limited to:

- **Best Practices and Research:** Continually monitor and communicate regulation and policy changes, new funding opportunities, deficiencies and best-practices seen in other states and in the private market, and both systematic and programmatic recommended remediation.
- **Compliance:** Conform to all HIPAA, Federal and State requirements for security and confidentiality; ensure System compliance; inform Members of their rights and responsibilities under the program; and perform compliance monitoring and reporting.

- **Regulatory & Standards Monitoring:** Monitor changes to HIPAA, Federal and State policies, NCCI Standards, etc. and recommend a best practice based course of action to the State when changes are required.

- **Service Representative Training:** Develop and maintain an ongoing training program for Member services representatives. Materials must be reviewed and approved by the State.

- **Performance Reporting:** Provide monthly reports capturing performance against the SLRs governing these services.

- **Provider Satisfaction Surveys:** Administer surveys to Providers to measure satisfaction with the services provided.

3.7.2.2 Member Services

The Member Services to be provided include, but are not limited to:

- **Health Improvement Outreach:** Develop approved health benefit campaigns for specific target populations. Provide ongoing advice and recommendations about additional outreach based on specific population criteria including, but not limited to: diagnosis, geography, and demographics.

- **Manage Member Communications**: Develop communications for Members including, but not limited to, newsletters and other publications.

3.7.2.3 Provider Management

The Provider Management Services to be provided include, but are not limited to:

- **Provider Training and Outreach:** On a schedule to be determined in negotiation with the State, the Vendor will provide ongoing training of Providers on the use of the MMIS. In addition, the Vendor will continually monitor and report on recurring errors and issues in the use of the System by Providers and will conduct targeted trainings aimed at reducing the recurrence of the issue.

3.7.2.4 Operations Management

The Operations Management Services to be provided include, but are not limited to:

- **Claims Processing:** Receive and adjudicate all claims, including electronic and paper claims and claims triggered within the MMIS by user-defined criteria; scan paper claims received; audit, validate and analyze claims data to ensure the claims process is effective and producing high quality results; and training and on-line tools related to claims processing.

- **Plan Management:** Perform impact analysis on any prospective plan change and provide results to the State.
- **Mass Adjustments:** Coordinate mass adjustments including, but not limited to: Provider communications and reconciliation and additional payments to identified Providers triggered by imported risk-adjustment calculations.
- **Data and Reports:** Support claims and authorizations data entry/scanning so reports can be generated to meet the State's business needs.
- **Process Improvement:** Monitor ongoing operations and continually implement process improvements.
- **Medicaid Bus Voucher Program Functions:** The Vendor will manage and track the issuance of bus vouchers

3.7.2.5 Financial Management

The Financial Management Services to be provided include, but are not limited to:

- **Accounts Receivable:** Generate invoices; receive payments; enter payment information; and post payments against outstanding Accounts Receivables.
- **Accounts Payable:** Establish payment information; receive funds; and generate payments to other entities.
- **Incentive Payments:** Determine and track qualification, certification and eligibility.
- **Budgeting:** Generate established reports; ad hoc reporting as needed; and analysis of Federal mandates.
- **Reporting and Document Generation:** 1099 generation and management; generate reports periodically or as-needed; develop new standardized, parameterized and ad hoc queries / reports; through integration with other systems, report on payments made outside of the MMIS; and feed appropriate information to other State systems such as VISION, the State financial system.

3.7.2.6 Data Analytics

The Data Analytics Services to be provided include, but are not limited to:

- **Program Integrity:** Support Program Integrity initiatives and identify patterns of abnormal activity and possible fraud, waste and abuse activity.

- **Reporting and Analytics:** Provide support, guidance and training on the use of the Reporting and Analytics systems and tools and the analytical methods and techniques deployed to meet business objectives.

- **Perform Analysis:** Conduct analysis on and produce Provider reports and report cards, utilization reports and monthly operational reports according to State needs and requirements.

- **Data:** Provide support, guidance and training on understanding the meaning and structure of the MMIS data available.

3.8 Proposed Contact Center Solution and Services

3.8.1 Summary of Contact Center Service Requirements

The Vendor will be responsible for providing Contact Center services for AHS. System and Service requirements are found in Response Template G.3 – Contact Center Functional Requirements and Response Template H.3 – Contact Center Requirements Approach. These response templates capture the System requirements and Services the Vendor will provide in performing the business processes for the State after go-live. These activities must meet the Service Level Requirements (SLR) outlined in other sections of this document. These are in addition to the System M&O processes and activities outlined within the Non-Functional Requirements.

3.8.1.1 General Services

The General Services to be provided include, but are not limited to:

- **Performance Reporting:** Provide monthly, weekly and daily reports capturing performance against the SLRs governing these services.

- **Member Satisfaction Surveys:** Administer surveys to Members to measure satisfaction with the services provided.

3.8.1.2 Member Services

Vendor will provide the following enrollment, benefit counseling, and other services for Green Mountain Care Members.

- **Publicly Funded Program Member Support:** The Vendor will inform the eligible population and other interested individuals about the State health care programs including Primary Care Plus and the Bus Voucher Program. Information will include program policies, time lines and benefits.

- **Publicly Funded Program Member Enrollment Functions:** The Vendor will enroll eligible individuals into health care programs managed by the State, following specific procedures that have been developed and agreed upon by the State and Vendor. The Vendor will accept, record and follow the appropriate processes work flow for Member Fair Hearing Grievances and Appeals. In addition to receiving Member requests for the Bus Voucher Program and sending Bus Vouchers to Members, the vendor will verify both a Member's program eligibility and the upcoming medical appointment before providing a Bus Voucher for that trip.

- **Health Benefits Exchange (HBE), Qualified Health Plans (QHP) Functions:** The Vendor will provide customer support functions that include the use of navigators, brokers and other assistor support for individuals, families, small group employers and their employees. Vendor will ensure delivery of equal service levels to HBE customers and members of state publicly funded plans.

In addition, the Vendor will be responsible for **Member Communications and Outreach:** Generate and manage Member correspondence and notifications related to enrollment, benefits, services, etc.

3.8.1.3 Provider Management

The Vendor will provide customer service support to current and prospective Green Mountain Care Providers. The Provider Management functionality provides the ability to capture, manage, and maintain information for the State's prospective or enrolled Providers and support the enrollment business processes. This area also supports the business processes involved in communications between the State and the prospective or enrolled Providers. Communication management functions include, but are not limited to: Provider correspondence and notifications and outreach and education.

- **Provider Eligibility, Enrollment and Disenrollment:** Determine a Provider's eligibility, verify licensing/credentialing, enroll to provide specific services or benefits, manage aggregation of Providers in flexible groupings for evolving payment strategies (including ACO, Shared Savings, etc.), and process dis-enrollments when appropriate.

- **Provider Information Management:** Maintain Provider-specific information and provide authorized users access to inquire, view and edit the information.

- **Provider Licensure and Certifications**: Manage the information on licensure and certifications of Providers, including accessing other State and non-State systems to verify all required aspects of licensure and certification.

- **Provider Inquiries, Communication and Outreach:** Generate Provider-specific correspondence as well as conduct outreach to groups of Providers. Provider

communications may take multiple coordinated forms (e.g., banners, newsletters) and must include a method of facilitating routine/frequent communication between Providers and the State.

- **Provider Grievance and Appeals:** Capture all actions and milestones related to the filing and hearing of Provider appeals and grievances.
- **Trained staff:** Maintain a fully trained staff to research and respond to all types of inquiries, including:
  - Procedure and coverage inquiries
  - Program benefits and program limitations
  - Consumer responsibility for copayment, coinsurance, deductible, spend-down or patient share and non-covered services
  - Claims processing and payment requirements
  - Claims status
  - Consumer- Fair Hearings, Grievances or Appeals
  - Provider Grievances and Appeals
  - Billing questions
  - Provider eligibility and enrollment status
  - Member eligibility status
  - Policy changes
  - Requests for manuals and forms
  - Prior authorization process and information
  - Denial clarification
  - Questions regarding agency correspondence
  - Receive, record and initiate the appropriate processes when a member has a change in circumstance, including but not limited to; household, income, job change, address change, birth/adoption of a child, etc.

3.9 Summary of Non-Functional Requirements

The State has developed and documented a set of Non-Functional Requirements (NFR) for the MMIS and Contact Center. These NFRs are independent of any particular Vendor's solution and are intended to align the Vendor's offering(s) with the overall State vision for integrated health and human services and the enterprise technology infrastructure being deployed. These requirements deal with a variety of areas including:

- The usability of the technologies
- The specific levels of performance required of the technologies
- The need for the technologies to comply with federal and state laws, regulations and standards (e.g., HIPAA and MITA)
- State of Vermont standards and preferences for certain technologies

The Vendor must respond to the NFRs and provide its approach to meeting them using Response Template I – Non-Functional Requirements and Response Template J – Technical Requirements Approach.

In Response Template I – Non-Functional Requirements, the NFRs are organized under the following categories:

3.9.1 Use and Performance Requirements

Use and Performance Requirements include those that are identified for all in-scope business activities (e.g., claims processing, customer service). All the requirements in this section are of particular interest to business and Project stakeholders. These requirements are organized as follows:

- U1 - Usability
- U2 - Audit / Compliance
- U3 - Service Level Requirements (SLRs) and Performance
- U4 - Interface List

3.9.2 Technology Requirements

Technology Requirements include those that drive how systems should be designed and built in a way that provides for long-term use and reuse and related standards (e.g., SOA, compliance with adopted standards, MITA 3.0 and CMS' Seven Conditions and Standards), as well as

defining the minimum set of technical capabilities expected from certain infrastructure components. These requirements are organized as follows:

- T1 - Service Oriented Architecture (SOA)
- T2 - Interoperability / Interfaces
- T3 - Scalability and Extensibility
- T4 - Regulatory and Security
- T5 - Data Integration - ETL
- T6 - Business Intelligence and Reporting
- T7 - Business Intelligence Information Management Infrastructure
- T8 - Enterprise Content Management
- T9 - Rules Engine
- T10 - Portal
- T11 - Application Server
- T12 - Database Management System
- T13 - Business Process and Case Management
- T14 - Application/Transaction Monitoring and Logging
- T15 - HSE Platform Alignment Requirements

3.9.3 Implementation Requirements

Implementation Requirements include those that drive how systems and services are designed and implemented to reduce risks and promote quality (e.g., project management, Software Development Life Cycle (SDLC), quality control). These requirements are organized as follows:

- I1 - Project Management
- I2 - Environment Installation and Configuration
- I3 - Knowledge Transfer & Training
- I4 - Design, Development & Customization
- I5 - Deployment

- I6 - Quality Management

3.9.4 Operations Requirements

Operations Requirements include those that drive how systems and services are operated and supported to reduce risks and promote quality. These requirements are organized as follows:

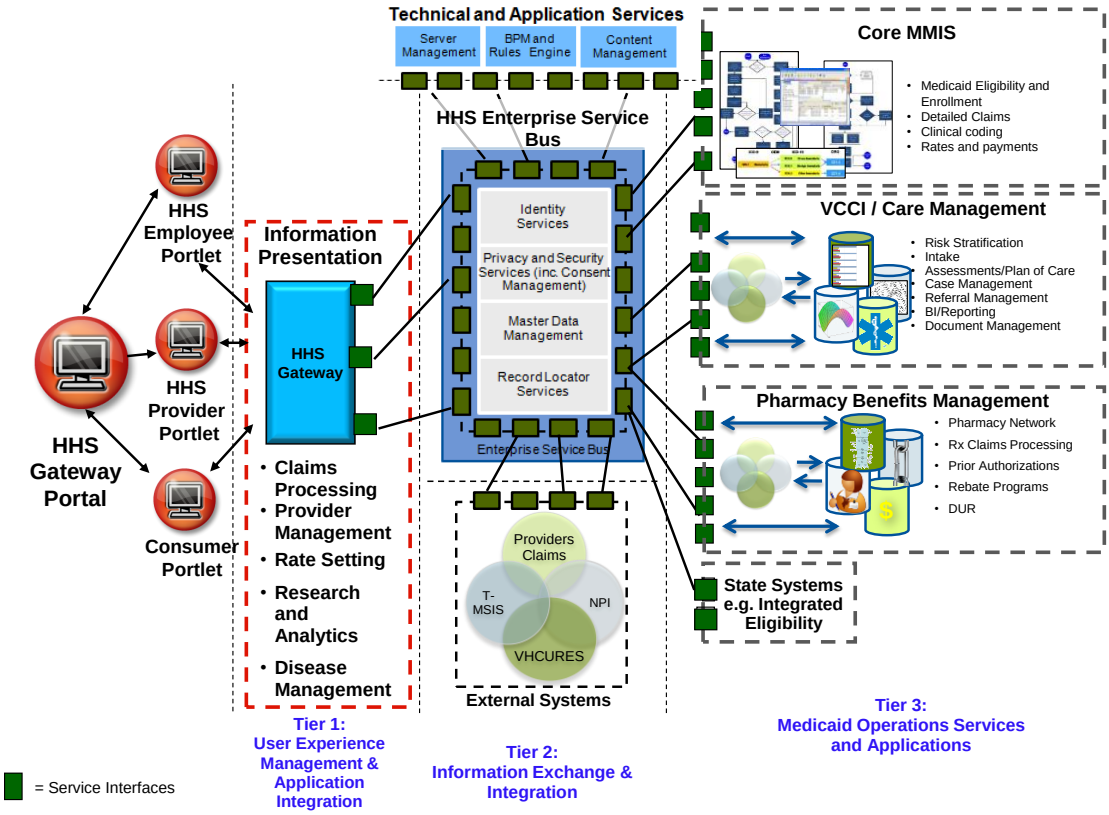
- O1 - Production Support & Transition
- O2 - Defect Resolution and Solution Acceptance
- O3 - System Administration
- O4 - System Management
- O5 - Hosting

3.10 Solution Architecture Guiding Principles

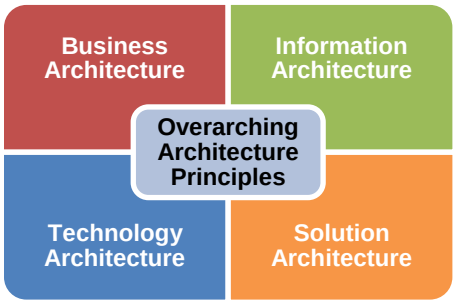
The State is seeking the implementation of innovative, flexible and interoperable solutions that provide the key capabilities required for meeting the State's business or technical objectives. The figure below provides a high-level conceptual model of the Vermont HSE solution architecture. The Solution Architecture Conceptual Model diagram presented below is separated into three (3) major architecture tiers:

- Tier 1 – User Experience Management and Application Integration
- Tier 2 – Information Exchange and Integration
- Tier 3 – Medicaid Operations Services and Applications

Figure 17. Vermont HSE Solution Architecture Conceptual Model



A key objective of the Vermont Enterprise Architecture (EA) framework for the HSE Program is to organize the EA content and define the desired future state capabilities. The State has defined a series of architectural principles that describe the desired future state EA for the Vermont HSE Program. The Vendor must align its solution with these principles in its overall solution approach.



The Vermont HSE Architecture consists of four (4) key domains:

- **Enterprise Business Architecture** – Defining the drivers and strategy for the future program/policy framework for Vermont's integrated and enterprise approach to health and human services and identifying the implications for enabling IT and developing a functional model of the enterprise from which information and technical architectures can be derived.

- **Enterprise Information Architecture** – Identifying the data and information that will be required to anticipate, support and validate key decisions through the lifecycle of

Vermont's health and human services programs/services and how that data/information must flow through the State's legacy systems.

- **Enterprise Technology Architecture** – Defining the required technology infrastructure and standards (ONC, National HIT Standards, Software/Hardware Standards, etc.) as well as the system management, operations and security mechanisms that are required to achieve the vision and provide for a sustainable, extensible, lifecycle of State programs and services.

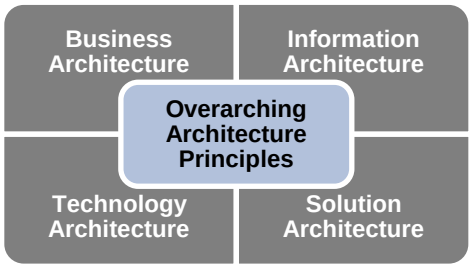
- **Solution (Application) Architecture** – Defining the required solution pattern that will be required, such as: common front-end one-stop portal; enterprise information exchange/enterprise service bus; consolidation / modernization / retirement of legacy applications; enterprise data warehouse/mart and business intelligence tools.

Architectural Principles by Domain

Architectural principles provide guidance for decision-making in support of the vision of the future state. The principles describe the consistent decision-making biases and are intended to provide logical consistency across multiple areas. The principles also articulate how to deal with change, drive behavior, and affect individual decision-making events. These principles are not policies, but often do drive the policy requirements. These principles articulate top-level decision-making biases at Vermont.

The following overarching **HSE Architecture** principles support the HSE Platform:

- **Sustainability:** The HSE Architecture must include essential actions and resources to ensure the endurance of the Vermont HSE. This requires committed leadership, effective governance and the continuity of funding and knowledgeable resources with the critical skills to sustain the architecture



- **Open Process:** Establish an open and inclusive process for defining the EA, identifying the needs of the community (Providers, payers, government, etc.) and the Business, Information and Technology architecture

- **Accountability and Transparency:** There must be clearly defined ownership and governance for the architecture. Roles and responsibilities must be delineated unambiguously and shared openly. Defined responsibilities should include: providing input to the decision making process, analyzing alternatives, formulating proposals, making determinations and review and approval

- **Simplicity and Consistency:** EA governance processes must serve to avoid unnecessary complexity and redundancy in the management of risks and controls across the enterprise by developing a single, unified approach

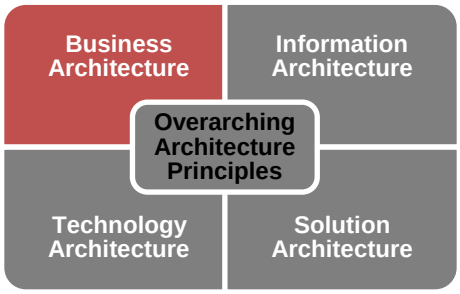
- **Broad Participation:** The State has identified a need for broad stakeholder representation and involvement in EA Governance

- **Aligned and Comprehensive:** The value of EA will depend in large measure on how well it supports program requirements in all respects

The following **Enterprise Business Architecture** principles support the HSE Platform:

- **Support the Enterprise Mission and Objectives:** All business processes should be optimized to support overall State strategic objectives

- **Focus on User Needs:** Members, State staff and Trading Partners will be able to use systems that provide content rich and user friendly interfaces via multiple channels and task-appropriate devices aligned with the State's model of practices



- **Enable Data Sharing:** The HSE Platform will enable enterprise-wide data sharing and also provide flexible data access for Members and Trading Partners

- **Ensure Privacy and Confidentiality:** The HSE Platform will ensure the privacy and confidentiality of health data including compliance with all laws and regulations

- **Enhance Decision-support:** The HSE Platform will provide timely, accurate, and complete decision support information to users through applications and shared services that minimize the labor intensity to enter, access and manipulate data and also anticipate, support and validate key public health and client service activities and decisions

- **Utilize Advanced Data Analytics:** The HSE Platform will collect and marshal a wide variety of health data that will be analyzed to create knowledge that informs evidence-based strategies to create actionable results for meeting the needs of Members

- **Create a Real-Time Integrated Enterprise:** The HSE Platform will allow all users to have current and up-to-the-second information regarding all client's interactions with Vermont's HHS programs

The following **Enterprise Information Architecture** principles support the HSE Platform:

- **Manage Information as an Enterprise Asset:** Coordinate the collection, consolidation, and consumption of enterprise information to support strategic initiatives requiring the consistency and dependability of data across multiple business processes and throughout the entire lifecycle of the information

- **Enable Data Sharing via Standards-Based Approach:** State HHS agencies will provide and benefit from consistent and accessible data sharing, internally and externally, using appropriate Health IT standards for naming, messaging, and data exchange

- **Data Governance will be Transparent and Consistent:** The HSE Platform will ensure that data governance process decisions are consistently implemented across the organization to ensure that data integration is as effective as possible

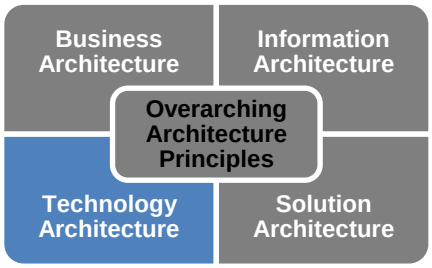
- **Establish a Single Data Source approach to Client and Provider Information:** The HSE Platform will use enterprise-wide tools to provide reliable and cost-effective data sources for the records managed by each agency and its partners

- **Continuously Improve Data Quality:** Data will be continuously reviewed and there will be a relentless focus on ensuring the highest quality of data content with specified data owners accountable for quality and establishing standards for data stewardship - addressing data definition, transformation, integrity and quality issues

- **Enforce Data Confidentiality and Legal Requirements:** The State will ensure that all rules and regulations that govern data collection, storage and use are rigorously applied

The following **Enterprise Technology Architecture** principles support the HSE Platform:

- **Integrated and Accessible Architecture:** Information captured across the program silos need to be integrated and accessible

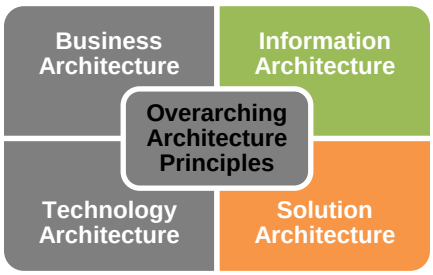


  - ❑ Leverage data across systems and processes, taking into account security, privacy and confidentiality considerations
  - ❑ Maintain consistent definitions and a single authoritative source of record for data

- **Robust Infrastructure Capabilities:** Enhance infrastructure capabilities for a standardized approach to health information
  - ❑ Need to deploy IT infrastructure for user driven access to and analysis of information

- **Privacy and Security Compliance:** Ensure privacy and security of participant information in accordance with legislative mandates (e.g., HIPAA) and community preferences
  - ❑ Improve and enforce the Security standards around Identity and Access Management (IAM)
- **Technology Solutions Aligned to Agency Requirements:** Design technology solutions to accommodate appropriate Agency requirements consistent with enterprise architecture and standards while minimizing the number of departmental applications (eliminating duplication and overlap wherever possible)

The following **Enterprise Solution Architecture** principles support the HSE Platform:



- **Service-Oriented:** The target architecture should consist of a number of services that are compliant with industry standards for service-oriented architecture to facilitate reuse, adaptability and interoperability
- **Interoperability Standards:** Build upon Federal standards and implementation efforts including CDC, CMS, NHIST, the ONC HIT Standards Committee and those for the NHIN and comply with emerging national interoperability standards for content exchange, vocabulary/notation and privacy/security
- **Investment Protection:** Provide the ability to integrate with existing public health system platforms and health information exchanges
- **Independence:** Keep architecture skills separate from product and implementation vendors' dependencies to maintain vendor and technology neutrality in the development of architecture
- **Scalable and Extensible:** Provide incremental expansion of functionality over time on a base that is scalable to accommodate additional users and extensible in expanding capabilities to meet future business needs and Federal and State mandates
- **Legacy System Access through Modernized Interfaces:** Provide the platform, design patterns and disciplines required to facilitate access to the existing application portfolio and data sets leveraging modern interface architecture approaches

3.10.1 State of Vermont Enterprise Considerations

The State has a largely decentralized technology structure with most large agencies and departments having their own IT resources. The Department of Information and Innovation

(DII) serves as the Enterprise IT organization for the State, hosting enterprise applications including email and Microsoft SharePoint. DII includes the Enterprise Project Management Office (EPMO) and the Office of the Enterprise Architecture/CTO. The Commissioner of DII is the State CIO. DII also manages the State's WAN and all telecommunications resources.

The Vendor's proposed System and Services shall ideally be "enterprise capable" and will be evaluated, in part, for its ability to serve a broader purpose across the State enterprise. Ideally, the State would like to enter into an enterprise contract and licensing terms that can serve the immediate needs of the core Medicaid operations and can also be expanded to any other agency or department. Part of the enterprise goal is to achieve economies of scale when possible in leveraging of software licenses, support and maintenance contracts, existing IT infrastructure, and by combining implementation and training costs across entities where feasible.

3.10.2 Interfacing Requirements

The MMIS will need to interact with a number of other State and Federal systems to function effectively. The MMIS should be designed to take full advantage of the enterprise application integration capabilities of the HSE Platform. The detailed interface requirements are described in Response Template I – Non-Functional Requirements and Response Template J – Technical Requirements Approach.

3.11 Required Project Policies, Guidelines and Methodologies

The Vendor must comply with all existing applicable laws, regulations, policies, standards and guidelines affecting information technology projects, and those which may be created or changed periodically. It is the responsibility of the Vendor to insure adherence and to remain abreast of new or revised laws, regulations, policies, standards and guidelines affecting Project execution and the System. Agency-specific confidentiality and privacy policies, such as those related to HIPAA and others may apply. These may include, but are not limited to:

- 2013 State of Vermont Act No. 79 "An act relating to health insurance, Medicaid, the Vermont Health Benefit Exchange, and the Green Mountain Care Board" and its requirement that MMIS have uniform and transparent edit standards and payment rules at:
  http://www.leg.state.vt.us/docs/2013/Acts/ACT079.pdf

- The State's Information Technology Policies & Procedures at:
  http://dii.vermont.gov/Policy_Central

- The State's Record Management Best Practice at:
  http://vermont-archives.org/records/standards/pdf/RecordsManagementBestPractice.pdf

- The State Information Security Best Practice Guideline at: http://vermont-archives.org/records/standards/pdf/InformationSecurityBestPractice_Eff.20090501.pdf
- The State Digital Imaging Guidelines at: http://vermont-archives.org/records/standards/pdf/ImagingGuideline2008.pdf
- The State File Formats Best Practice at: http://vermont-archives.org/records/standards/pdf/FileFormatsBestPractice_Eff.20071201.pdf

3.12 Proposed Solution Approach

3.12.1 Approach to Security Related Regulations and Standards

The proposed System(s) will, at a minimum, provide a mechanism to comply with security and safeguard requirements of the following Federal agencies / entities:

- Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)
- Administration for Children & Families (ACF)
- NIST 800-53 and DOD 8500.2
- Federal Information Security Management Act (FISMA) of 2002
- Health Insurance Portability and Accountability Act of 1996
- Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009
- Privacy Act of 1974
- All applicable Vermont privacy statutes
- e-Government Act of 2002
- Patient Protection and Affordable Care Act of 2010, Section 1561 Recommendations
- Vermont Statute 9 V.S.A. § 2440. Social security number protection (http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=09&Chapter=062&Section=02440)
- Vermont Statute 9 V.S.A. § 2435. Notice of security breaches (http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=09&Chapter=062&Section=02435)

3.12.2 Approach to Data Privacy

The Vendor will agree to comply with State and Federal confidentiality and information disclosure laws, rules and regulations applicable to work associated with this RFP including, but not limited to:

- United States Code 42 USC 1320d through 1320d-8 (HIPAA);
- Code of Federal Regulations, 42 CFR 431.300, 431.302, 431.305, 431.306, 435.945,45 CFR164.502 (e), 164.504 (e) and Part 2

Based on the determination that the functions to be performed in accordance with this RFP constitute Business Associate functions as defined in HIPAA, the Vendor shall execute a Business Associate Agreement as required by HIPAA regulations at 45 CFR §164.501.

The Vendor acknowledges its duty to become familiar with and comply, to the extent applicable, with all requirements of the Federal HIPAA, 42 U.S.C. § 1320d et seq. and implementing regulations including 45 CFR Parts 160 and 164. The Vendor also agrees to comply with the Vermont Privacy regulations.

The fully executed Business Associate Agreement (see Attachment E) must be submitted within ten (10) working days after notification of award or award of Contract, whichever is earlier. Should the Business Associate Agreement not be submitted upon expiration of the ten (10) day period as required by this solicitation, the Procurement Officer, upon approval by the Project executive sponsors, may withdraw the recommendation for an award and make an award to the next qualified Vendor.

Protected Health Information as defined in the HIPAA regulations at 45 CFR 160.103 and 164.501 means information transmitted that is individually identifiable; that is created or received by a health care Provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and that is related to the past, present, or future physical or mental health or condition of an individual, to the provision of health care to an individual, or to the past, present, or future payment for the provision of health care to an individual. The definition excludes certain education records as well as employment records held by a covered entity in its role as employer.

3.12.3 Approach to Capacity Planning

The Vendor is required to propose a robust approach to capacity planning. The MMIS and Contact Center design and implementation approach must be responsive to three (3) core dimensions of capacity planning: 1) business capacity planning, 2) service capacity planning, and 3) IT component capacity planning.

1. **Business Capacity Planning:** Ensures that the future business capacity requirements (e.g., desired outcomes, anticipated number and type of participants) are considered and understood, and that sufficient IT capacity to support the new System is planned and implemented within an appropriate timeframe

2. **Service Capacity Planning:** Projects the end-to-end performance, usage, workloads and resources of the MMIS and Medicaid Operations Services. It comprises monitoring, measurement, reporting and forward planning to assure compliance with the performance of the MMIS and Medicaid Operations Services as detailed in the SLR and Performance section of the NFR document and the Service Level Requirements outlined in section 2.15

3. **IT Component Capacity Planning:** Helps predict the performance, utilization, and capability of individual IT components. It also ensures that all components within the required IT infrastructure with finite resources are monitored and measured and that the collected data can be recorded, analyzed, and reported

The new System and its database must support the State's caseloads (active and inactive Members and historical participant data) and future caseload increases.

3.12.4 Approach to System Migration and Data Conversion

The Vendor must describe the migration approach and methodology to be used for the MMIS and Contact Center. The Vendor will incorporate the migration approach and data conversion plan into a comprehensive Deployment Plan. The State anticipates considerable collaboration with the Vendor in the construction of the migration and conversion plans.

3.12.5 Approach to Integration

The MMIS and Call Center solutions are expected to interface with a number of other State and non-State systems using the HSE Integration infrastructure.

The System must be able to support Application to Application (A2A) synchronous and asynchronous messaging using Web services. The messaging capabilities will be able to support a wide variety of A2A patterns including, but not limited to:

- Data look-up and retrieval
- Data look-up with services provided by other applications
- Simple bulk data transfer to/from other systems

It is anticipated that all integration will be through Vermont's HSE Integration infrastructure built on the Oracle Service Bus platform.

3.12.6 Approach to Testing

The Vendor is required to propose a robust and integrated methodology for Testing of the proposed System. The Vendor's testing approach and plan must, at a minimum, include the following areas:

- Test philosophy including objectives, required levels or types of testing, and basic strategy
- Procedures and approach to ensure the testing will satisfy specific objectives and demonstrate that the requirements are met
- Procedures and approach to ensure that each phase of the testing is complete, and confirmation that formal reports/debriefings will be conducted for each phase of testing
- Approach to define tested workload types (performance testing) and test data
- Overview of testing facilities, environment and specific testing tools to be used
- Overview of processes and procedures that will be used by the Vendor for releasing testing results and review of test results
- Process and procedures for tracking and reporting of results / variances / defects

3.12.7 Approach to Implementation

The Vendor must employ, maintain, and execute a project management methodology that complies with the Project Management Institute (PMI) standards or equivalent.

The Vendor must propose a project management approach and methodology to be used for all service configuration and deployment project lifecycles. The Vendor will develop and follow a Project Management Plan (PMP) conforming to the Project Management Body of Knowledge (PMBOK). The PMP will incorporate the following PMBOK knowledge areas:

- Project Integration Management
- Project Scope Management
- Project Time Management
- Project Cost Management
- Project Quality Management
- Project Human Resource Management
- Project Communications Management

- Project Risk Management
- Project Procurement Management
- Stakeholder Management

The Vendor must develop (in cooperation with the State) and execute a Knowledge Transfer and Training Plan. The Knowledge Transfer and Training Plan must include, at a minimum:

- Training goals/standards and the specific plan for training any State technical personnel and end users
- Size of population and types of roles that need training
- Strategy for providing training early in the Project to allow the training goals to be implemented throughout the Project lifecycle
- Tasks, deliverables and resources necessary to complete the training effort and identify tools and documentation that will be necessary to support proposed effort
- Types of training, the specific courses and course materials, the training approach for both technical personnel and end users, and how training effectiveness will be measured and addressed

3.12.8 Approach to Usability (User Interface)

The Vendor must describe its proposed approach to providing a User Interface that adheres to industry best practices and is simple, consistent, and uses familiar terminology. The State prefers to use the existing Oracle WebCenter Portal environment for the User Interface.

3.12.9 Approach to Business Intelligence, Analytics and Reporting

The Vendor must propose an approach to support the Business Intelligence (BI) functions that should deliver a balanced set of capabilities to the internal State users across three (3) areas: data integration, information delivery, and analysis. Additionally, the description must include the reporting approach for both canned and ad-hoc reports and the ability of the proposed System to provide dashboard capabilities to users.

3.12.10 Approach to Regulatory Policies and Audit Compliance

The Vendor must describe its approach to identifying and adhering to Regulatory Policies (both Federal and State) as well as achieving Audit Compliance. The description must include the process for system and policy remediation to allow the State to remain in timely compliance with all regulations, policies and procedures.

3.12.11 Approach to Audit Trail

The Vendor must propose an approach to support an Audit Trail of all pertinent events, giving due consideration to storage space and performance constraints.

Examples of these events include, but are not limited to:

- System start-up and shutdown
- Successful and unsuccessful login attempts
- User actions to access various System components (successful and unsuccessful attempts)
- Actions taken by system administrators and security personnel
- All administrative actions performed on the System
- Permission changes
- Creation of users and objects
- Change, deletion and modification of any system file
- Changes, additions or deletions to data (including operational and security data)
- Out of normal system operations usage or user access

The proposal should include how the Vendor will define which areas need audit capability, reporting and tracking, and timeline for maintaining the audited detail and reporting out this detail. The audit trails should include fine-level details as to the specific change made, by whom and on what date. Ideally the Vendor will have the ability to also report at the time of the change, what request or issue prompted such change.

3.12.12 Approach to Disaster Recovery

The Vendor must propose an approach to reestablishing operations within the required timeframes in the event causing a significant disruption of service. The Vendor must provide an overview of the facilities, hardware and software components utilized by the proposed System.

3.12.13 Approach to IT Service Desk

The Vendor must propose an approach for providing a professional Service Desk that is physically located in the United States, including all Service Desk staff. The IT Service Desk will enable the central management of end-user focused service support and delivery and will provide IT Service Management services and processes including, but not limited to:

- Incident Management
- Issue/Problem Management
- Change Management
- Service Requests

Service management handles and manages the resolution of Incidents, Problems and Changes. This set of services manages events as they occur, and assures escalation, ownership and closure of these events. The Service Desk should follow best practices based on ITIL v3 standards.

The following activities shall be provided during Service Operations:

- **Production Support:** Supporting production, addressing system interruptions, focusing on identifying and fixing system faults quickly or crafting workarounds and enabling problem management root cause analysis and problem remediation. On call support will be used for any Severity 1 maintenance requests
- **Maintenance Support:** Making changes to existing functionality and features that are necessary to continue proper system operation. This includes routine maintenance, root cause analysis, applying change requirements, software upgrades, business need changes, State rule changes, infrastructure policy impacts, and corrective, adaptive or perfective maintenance, as appropriate
- **Enhancement Support Analysis:** Capturing the functional and non-functional requirements for adding new functionality/features to the proposed System on prioritized requests from the user community. This includes interpreting any rule changes and other critical business needs from a technical and logistical standpoint
- **User Support:** Providing application-specific support coordinated through the IT Service Staff as well as conducting system research and inquiries
- **Helpdesk Platform:** The IT Helpdesk shall utilize a dedicated implementation of industry standard service desk software to be hosted by the Vendor and used by the State
- **Database Support:** This includes overall database administration including refactoring the proposed System to enhance database efficiency in storage and query response time

3.12.14 Approach to Software Configuration Management

Software Configuration Management includes the identification and maintenance of system software components and the relationships and dependencies among them. These activities include:

- Automatic capture and storage of IT Service to Application, Application-to-Component and Component-to-Component relationships
- Maintenance of the history of those relationships and any transformation required to appropriately manage and document (e.g., source control, version control, profiles, security plans) configuration changes affecting the application and its processing environment

The Vendor must propose specific tools and infrastructure for software configuration management.

3.12.15 Approach to Change and Release Management

Change and Release Management activities include services required to appropriately manage and document changes to the application and any of the constituent components being developed (e.g., impact analysis, version control, library management, turnover management, build management, parallel development). Change and Release Management also includes services required to appropriately plan, execute, and document changes to the underlying application development environment components. Pre- and post-change communication is central to these activities for business users. These include the following:

- **Library Management:** The classification, control, and storage of the physical components of the application
- **Version Control:** The maintenance, tracking, and auditing of modifications to an application's components over time, facilitating the restoration of an application to prior development or production stages including tracking of the change, the reason for the change, and the authorized person approving the change
- **Turnover Management:** The automated promotion of software changes across different phases of the lifecycle (e.g., development, unit test, systems test, and production), including management of the approval process, production turnover, reporting of turnover changes and software migration control

The Vendor must propose a centralized solution to automate and control the software Change and Release Management process.

- This software change and release management process will control migration patterns (i.e., how a given set of code moves from one environment to another)
- This software configuration management process will control versioning, access controls, data quality, etc. for each environment

3.12.16 Approach to Data Retention and Archiving

The Vendor must propose an approach to Data Retention and Archiving designed to support multiple layers of data backup protection using a combination of both disk based and tape based technologies to meet the Vendor's proposed System backup and recovery requirements.

3.12.17 Approach to Technology Hosting with Maintenance and Operations

The Vendor must propose an approach to Technology Hosting with Application and Infrastructure Maintenance and Operations that will best meet the requirements described in this RFP.

- The Vendor must agree to terms acceptable to the State regarding the confidentiality and security of State data. These terms may vary depending on the nature of the data to be stored by the Vendor. If applicable, the State may require compliance with State security standards, IRS requirements, HIPAA, HITECH and/or FISMA compliance and/or compliance with State law relating to the privacy of personally identifiable information, specifically Chapter 62 of the Vermont Statutes. Further, a selected Vendor hosting a State system may be a "data collector" for purposes of State law and shall be required to (i) comply with certain data breach notification requirements and (ii) indemnify the State for any third party claims against the State which may occur as a result of any data breach.
- The Vendor must agree to host all technologies within the continental United States of America and no data may leave the continental United States at any time.
- The State reserves the right to periodically audit the Vendor's application infrastructure to ensure physical and network infrastructure meets the configuration and security standards and adheres to relevant State policies governing the System.
- The State reserves the right to run non-intrusive network audits (basic port scans, etc.) randomly, without prior notice. More intrusive network and physical audits may be conducted on or off site with 24 hours' notice.
- The Vendor will have a third party perform methodology-based (such as OSSTM) penetration testing quarterly and will report the results of that testing to the State.

- The Vendor will agree to cause an SSAE 16 Type II audit certification to be conducted annually. The audit results and the Vendor's plan for addressing or resolution of the audit results shall be shared with the State.
- The Vendor will agree to terms acceptable to the State regarding System backup, disaster recovery planning and access to State data.
- The Vendor will be required to agree to disclose the hosting provider which will be acceptable to the State for purposes of the data to be stored and will not change the hosting provider without the prior written consent of the State.
- The Vendor will guarantee the service level terms of any hosting provider.
- The Vendor will agree to apply service level credits for the failure to meet service level terms.

3.13 Provision of Technology Hosting with Maintenance and Operations

The State has no plans to operate the technologies in a State Data Center and requires that the technologies be hosted either by the Vendor, a Subcontractor managed by the Vendor or be provided by a partnership with another qualified Vendor.

It is important for the Vendor to describe its chosen approach to technology hosting within its Proposal. Detailed hosting requirements have been included for response in Response Template I – Non-Functional Requirements and Response Template L – Maintenance Requirements Approach.

3.14 Green Mountain Care 2017, Vermont's Universal, Publicly-Financed Health Coverage Model

Vermont is on a path to developing and implementing universal coverage for all Vermont residents through a publicly financed model. In May 2011 the Vermont legislature passed Act 48 which recognizes the fiscal and economic imperative for Vermont to undertake fundamental reform of its health care system including the transition to a State-wide universal health care system targeted for 2017.

Green Mountain Care provides universal health care coverage to everyone living in Vermont. Health care benefits will be based on where people live, not where they work. Health coverage will be publicly funded, based on ability to pay. The goal is to save money for Vermonters by creating less hassle and less paperwork. Instead of multiple systems run by multiple insurers, Vermont will use a vendor or vendors – just like a large employer would today – which will create efficiencies and reduce costs.

In Green Mountain Care, all Vermont residents will be covered with a comprehensive set of health benefits. There will be a single one-stop approach to acquiring the necessary documentation that the state will need in order to cover residents with healthcare services and continue to draw down federal funding to support the healthcare system.

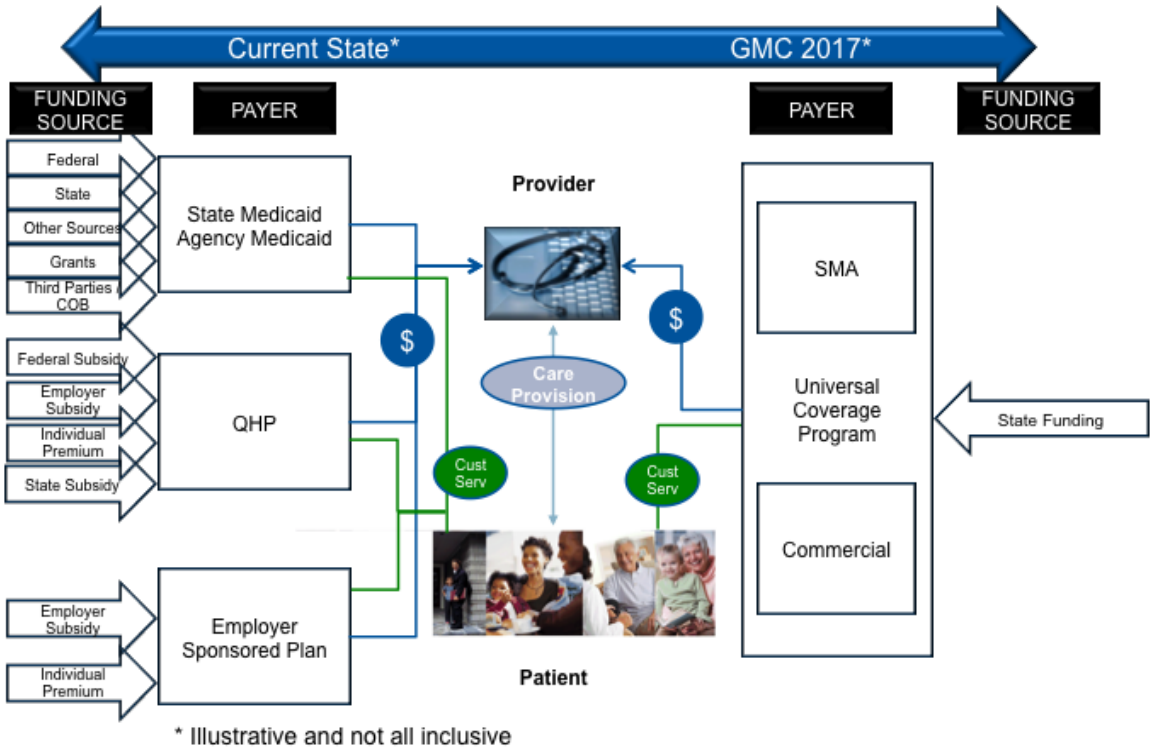
Current plans include the following:

- All Vermont residents will be enrolled automatically in Green Mountain Care (GMC).
- If individuals have other coverage (e.g., ESI or Medicare), the other coverage would pay first and GMC would supplement as needed ("GMC Secondary"); Medicaid is the payer of last resort.
- GMC will provide comprehensive health care benefits, including at minimum the federal essential health benefits required by the Affordable Care Act, such as:
    - comprehensive mental health and substance abuse services,
    - pharmaceuticals,
    - pediatric dental and vision care, and
    - care coordination

Vermont will contract with service providers that will manage the relationships with the various funding sources, the full range of accredited providers, and all Vermonters. In addition, the service providers will process claims for the full range of covered services. The future model will manage more funding sources than Medicaid does today (for example, the pass through funding available through an Affordable Care Act waiver under Section 1332), but it will also be simpler because there will be universal coverage and well-defined single responsibilities for all processes.

While the transition to GMC 2017 is not included in this procurement, the State wants assurances that the procured MMIS and Contact Center solutions will be adaptable, extensible and scalable to support the administration of the Green Mountain Care solution in the future.

Figure 17. Conceptual View of the Transition to Go Green Mountain Core 2017, Vermont's Universal, Publicly-Financial Health Coverage Model



3.15 System, Medicaid Operations Services and Contact Center Performance Management

To ensure the highest possibility for success in implementation and ongoing operations, the State requires a performance management capability that the Vendor will actively support. Both systems and services, the MMIS / Medicaid Operations Services and the Contact Center will be monitored and managed.

3.15.1 Performance Reporting

The State will monitor the performance of the Vendor from Project start-up until the technologies are implemented, the technologies during the System Maintenance and Operations Phase, and the Medicaid Operations Services Vendor's performance during the Operations Phase using a performance reporting system to be determined prior to Contract award. Response Template H.2 – Services Requirements Approach provides SLRs that specify the performance level that is expected in a particular area and is to be measured and reported each month by the Vendor.

3.15.1.1 Monthly Reporting

The Vendor must monitor performance against the specified Service Level Agreements (SLA), and will develop operations reports to demonstrate compliance with applicable SLAs. The

Vendor must submit a performance report card monthly on all SLAs, regarding the prior month's performance, no later than the 10th of the month. The Vendor may include additional information regarding SLA compliance in its report. The Vendor is to make available to the State, upon request, all reports or data used in the determination of SLA compliance and calculation of SLA metrics.

3.15.1.2 Corrective Action Report

When a SLA is not met, the Vendor must provide a written, detailed Corrective Action Report that describes:

1. The missed SLA
2. Full description of the issue
3. Cause of the problem
4. Risks related to the issue
5. The resolution, including any failed solutions implemented prior to resolution
6. Proposed corrective action to avoid missing the SLA in the future
7. Target resolution date
8. Effort required to correct

Upon receipt of the report, the State may request a meeting to further discuss related issues. The Vendor will implement the proposed corrective action (#6 above) only upon approval from the State.

3.15.1.3 Periodic Reviews

Prior to commencement of Routine Operations, the State and the Vendor are to review all SLAs to determine if revisions are needed. Thereafter, similar reviews are to be held annually, upon the implementation of a change that impacts existing SLAs, and/or at the request of the State.

3.15.1.4 Measurement Process and Auditability

All sampling of processes and outcomes, as required for the contracted SLAs, will be performed and reported on by the Vendor. The Vendor will allow verification of the process and results by the State when requested. The sampling rate to ensure compliance with the contracted SLAs will be calculated by the Vendor to provide a 95% confidence level, as defined by the appropriate statistical theory.

3.15.2 Implementation Measures

To ensure the System is implemented in alignment with the State's requirements and that the implementation progresses in accordance with the agreed plans, the Vendor must meet the following Implementation SLRs.

Table 20. Implementation Measures and Measurement Criteria

SLR NAME	SERVICE LEVEL REQUIREMENT	MEASUREMENT OF NONCOMPLIANCE	FREQUENCY OF MEASUREMENT
Milestone Completion for Milestones on the Critical Path	All milestones on the critical path to be completed by baseline completion date.	Any critical path milestone where the actual completion dates are later than the baseline completion date.	Weekly
Milestone Completion for Milestones NOT on the Critical Path	95% or more milestones NOT on the critical path to be completed by baseline completion date.	More than 5% of all the milestones NOT on the critical path where the actual completion dates are later than the baseline completion date.	Weekly
Functional Requirements Met	98% of Functional Requirements included in the phase are signed off as having passed user acceptance testing.	More than 2% of all the Functional Requirements included in the phase do not get as far as passing user acceptance testing before the phase goes live.	Implementation Phase

3.15.3 System M&O Performance Measures

To ensure the State goals and objectives for the technologies are met, the Vendor must meet the following System Performance SLRs.

Table 21. System Performance Measures and Measurement Criteria

SLR NAME	SERVICE LEVEL REQUIREMENT	MEASUREMENT OF NONCOMPLIANCE	FREQUENCY OF MEASUREMENT
Virus Contamination	All software developed and delivered by the Vendor must be free of viruses.	Each virus that is included in software developed and delivered by the Vendor.	Monthly

SLR NAME	SERVICE LEVEL REQUIREMENT	MEASUREMENT OF NONCOMPLIANCE	FREQUENCY OF MEASUREMENT
On-line Availability	The components of the System under Vendor control as delivered into production shall be available at a level agreed to in the Contract (the contracted target level of availability). This will be chosen from one (1) of the three (3) availability levels shown in Table 17 Levels of Availability of the future MMIS.	Each tenth of percentage point less than the contracted level of availability.	Monthly
On-line Search and Lookup Queries Response Times	The System response time during operations will be five (5) seconds or less for 95% of the search and lookup queries (does not include ad hoc queries and analytics). Maximum response time will not exceed 15 seconds except for agreed to exclusions. Response time is defined as the time elapsed after depressing an ENTER key (or clicking on a button that submits the screen for processing) until a response is received back on the same screen.	Each 0.5 second that the monthly average response time exceeds the maximum response time.	Monthly
Dashboard Report Response Times	The System will return a Dashboard report within 5 seconds or less, 95% of the time.	Each 0.5 second that the monthly average response time exceeds the maximum response time.	Monthly
Static Standard Report Response Times	The System will return a Static Standard report within 5 seconds or less, 95% of the time.	Each 0.5 second that the monthly average response time exceeds the maximum response time.	Monthly
Parameter-based Report Response Times	The System will return a parameter-based report within 20 seconds or less.	Each 0.5 second that the monthly average response time exceeds the maximum response time.	Monthly

SLR NAME	SERVICE LEVEL REQUIREMENT	MEASUREMENT OF NONCOMPLIANCE	FREQUENCY OF MEASUREMENT
Online Application Response Times	The System will achieve performance for interactive transactions other than the reporting-related transactions above, conforming to the minimum acceptable performance standard of 5 seconds response time, for 95% of interactions.	Each 0.5 second that the monthly average response time exceeds the maximum response time.	Monthly
Software Maintenance Request Resolution Times: ***Severity 1 - Emergency**	The service provider must resolve Severity 1 Maintenance requests within 4 hours.	Each hour beyond the requirement for resolving Severity 1 Maintenance requests.	Monthly
Software Maintenance Request Resolution Times: ***Severity 2 - Urgent**	The service provider must resolve Severity 2 Maintenance requests within 8 hours.	Each hour beyond the requirement for resolving Severity 2 Maintenance requests.	Monthly
Software Maintenance Request Resolution Times: ***Severity 3 - Important**	The service provider must resolve Severity 3 Maintenance requests within 3 calendar days.	Each calendar day beyond the requirement for resolving Severity 3 Maintenance requests.	Monthly

SLR NAME	SERVICE LEVEL REQUIREMENT	MEASUREMENT OF NONCOMPLIANCE	FREQUENCY OF MEASUREMENT
Quality of Code Delivered to UAT	All priority 3 or higher defects (testing defects) resulting from software development activities shall be resolved by the Vendor prior to the software being delivered for User Acceptance Testing and prior to deployment to production.	Each priority 3 or higher defect that is uncovered in UAT.	Monthly after start of the UAT phase of each Phase
UAT Defect Resolution Times: **Response to *Priority 1 test defect**	The Vendor must respond to priority 1 test defects within 1 hour.	Each instance that a response is not provided within the required timeframe for each test defect.	Monthly after start of the UAT phase of each Phase
UAT Defect Resolution Times: **Response to *Priority 2 test defect**	The Vendor must resolve priority 2 test defects within 4 hours.	Each instance that a response is not provided within the required timeframe for each test defect.	Monthly after start of the UAT phase of each Phase
UAT Defect Resolution Times: **Response to *Priority 3 test defect**	The Vendor must respond to priority 3 test defects within 8 hours.	Each instance that a response is not provided within the required timeframe for each test defect.	Monthly after start of the UAT phase of each Phase
UAT Defect Resolution Times: **Response to *Priority 4 test defect**	The Vendor must respond to priority 4 test defects within 5 days.	Each instance that a response is not provided within the required timeframe for each test defect.	Monthly after start of the UAT phase of each Phase

SLR NAME	SERVICE LEVEL REQUIREMENT	MEASUREMENT OF NONCOMPLIANCE	FREQUENCY OF MEASUREMENT
UAT Defect Resolution Times: **Response to *Priority 5 test defect**	The Vendor must respond to priority 5 test defects with each reporting phase (timeframe to be determined with State).	Each instance that a response is not provided within the required timeframe for each test report.	Monthly after start of the UAT phase of each Phase
Disaster Recovery RTO	The System's Recovery Time Objective (RTO) will be within 4 hours. In case of a disaster that affects the MMIS operations, the entire service will be restored within 4 hours.	For each 10 minutes longer than the 4 hours it takes to restore the entire service.	Annual review of any disaster incidents.
Disaster Recovery RPO	The System's Recovery Point Objective (RPO) will be no more than 1 hour of data loss. In case of a disaster that affects the MMIS operations, 1 hour of data inputs to the System (but no more) may be lost and needs to be re-entered.	For each 10 minutes more than 1 hour of data loss.	Annual review of any disaster incidents
Disaster Recovery Testing	The System must be completely tested, and supporting evidence of testing and acceptable functionality provided to the State every year	Each year test not completed Each functional component identified as not within compliance	Annually
Corrective Action Plans	Submit a Corrective Action Plan, within 5 business days of notification of system deficiencies	Each day after 10 business days that an agreed CAP is not produced	Annually

Table 22. System Helpdesk Service Measures and Measurement Criteria

SLR NAME	SERVICE LEVEL REQUIREMENT	MEASUREMENT OF NONCOMPLIANCE	FREQUENCY OF MEASUREMENT
Helpdesk Availability	The helpdesk environment and operations are fully available for normal business operations 99.5% of the time.	The helpdesk is not fully available for more than .5% of the week as compared with the contracted schedule of hours.	Weekly

SLR NAME	SERVICE LEVEL REQUIREMENT	MEASUREMENT OF NONCOMPLIANCE	FREQUENCY OF MEASUREMENT
Help Desk Call Answer Time	Live helpdesk representatives will answer 90% of calls or more in less than 30 seconds.	More than 10% of calls in the week take 30 seconds or longer to be answered by a live helpdesk representative.	Weekly
Rate of Abandoned Calls	5% of calls, or fewer, that come into the helpdesk either hang up or are disconnected before the helpdesk representative answers the call.	More than 5% of calls in the week are abandoned.	Weekly
First Call Resolution Rate	80% of calls, or more, are completed on first contact. First contact completion applies when the first person the customer reaches either answers the question, resolves the problem, or dispatches service where appropriate. Warm transfers and callbacks are considered second or greater contact. This will be allowed at 40% for the first two (2) months with 5% monthly increases until first call resolution rate equals or exceeds 80%.	In the steady state more than 20% of calls in the month are not resolved on first contact.	Monthly
Follow-on Calls due to Repeated Problem after Initial Fix Failed	5%, or fewer, of calls initiated to resolve an issue previously closed by the helpdesk. This will be allowed at 10% for the first two (2) months with a 1% reduction per month until 5% is achieved.	In the steady state more than 5% of calls in the month are initiated to resolve an issue previously closed by the helpdesk.	Monthly
Account Establishment / Changes	100% of account establishment or change requests will be completed within 5 business days of the request	Each day over 5 business days an account establishment or change request is outstanding	Monthly

3.15.3.1 System Availability

System availability is defined as the percentage of possible uptime in a month that the technology environments (including all associated components) are available to users or to perform in a back-up capacity, including all weekends and holidays. Negotiated scheduled downtime for System maintenance during off-peak hours is not included in the calculation of System availability.

Downtime is defined as the time during which the technologies are not functioning/available due to hardware, operating system or application program failure. Production downtime is defined as the time during which the System is not available for production use.

System availability is to be based on the following hours of operation:

- **Technology Hours of Operation:** All technologies are to be available 100% of the time 24 hours per day, 7 days per week, 365 days a year, except for agreed upon down time.
- **Other Components Hours of Operation:** The web portals and other System components, as required by the State, are to be available 100% of the time 24 hours per day, 7 days per week, 365 days a year, except for agreed upon down time.

The table below shows levels of availability that the State expects the Vendor to propose at differing price levels. For the Contract, one (1) level of availability will be chosen (the contracted target level of availability).

Table 23. Levels of Availability of the Future MMIS

AVAILABILITY %	DOWNTIME PER YEAR	DOWNTIME PER MONTH	DOWNTIME PER WEEK
99.9% (“three nines”)	8.76 hrs	43.2 min	10.1 min
99.95%	4.38 hrs	21.56 min	5.04 min
99.99% (“four nines”)	52.56 min	4.32 min	1.01 min

Scheduled/planned downtime for system maintenance should not be included in these calculations. Any scheduled downtime must be pre-approved by the State and must average less than 4 hours per week.

The levels of availability do not apply to development and test environments. Downtime for these environments must be less than 5% excluding pre-approved scheduled downtime.

3.15.4 Medicaid Operations Services and Contact Center Services Performance Measures

The State will monitor the performance of the Contract(s) issued under this RFP. All services must be provided at an acceptable level of quality and in a manner consistent with acceptable industry standards, custom and practice.

3.15.4.1 General Services

The State and Vendor shall establish mutually agreed upon satisfaction surveys during Contract finalization – including survey format, timeframe and method / process. The Vendor must take into account reactivity, support, quality of service and relationship, rated from zero (0) to ten (10).

The Vendor must meet the following Medicaid Operations Services general service levels and performance standards.

Table 24. Medicaid Operations Services Service Levels – General Services

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF MEASUREMENT
Compliance	Compliance with Federal and State standards including, but not limited to HIPAA and ACA.	The operations and processes must meet all HIPAA, Federal and State standards.	Quarterly
Reporting	Delivery of weekly and monthly status reports	Deliver 100% weekly and monthly written status reports by the agreed day/date	Monthly
Documentation	Update all System and process documentation when approved by the State	Deliver documentation updates within 5 workdays of State approval of implementation of the change	Monthly
Staffing	Fill vacant positions with staff within the agreed timeframe	Fill vacant positions with staff of equal ability and qualifications within 30 calendar days of initial vacancy.	Monthly

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF MEASUREMENT
Change Requests	Report on change requests	Track and report progress on 100% of change requests to the State with: Weekly progress reports with the current status of system changes. Monthly summary report with lists of all completed and outstanding change requests with estimated personnel hours to complete them, by status and priority.	Weekly / Monthly
	Document change requests	Provide a written response to 100% of change requests within 5 workdays of receipt of the change request with a clear and complete description of the change request, assessment of any perceived problems that may impact operations, constraints, assumptions, targeted completion date and effort to complete	Monthly
	Complete Change System Requests (CSRs) in a timely manner	Complete 100% of change requests by within the following timeframes as estimated in the Vendor response to the CSR: * 25 hours or less: Within 10 business days * 100 hours or less: Within 20 business days * More than 100 hours: Managed as a project	Monthly

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF MEASUREMENT
Training	Training documentation must be updated prior to process or System changes are implemented and quarterly to address quality issues, as requested by the State. Training materials are approved by the State in advance of the Training.	Trainings updated prior to process or System changes are implemented, and on a quarterly-basis or upon request by the State.	Quarterly
	Training satisfaction measured through surveys after training sessions.	All items are scored out of ten (10) by survey recipients; 80% of all scores must be greater than seven (7).	Quarterly
Quarterly High-level Survey	Selected State management staff, Providers and Members, surveyed quarterly, score the service no lower than seven (7) out of ten (10).	All items are scored out of ten (10) by survey recipients and any scores less than seven (7) are counted as a failure to meet the service level.	Quarterly
Annual Satisfaction Survey	State staff, Providers and Members, surveyed annually, score the service no lower than seven (7) out of ten (10).	An annual survey is administered to all State staff who work with the Vendor and System. Items scored seven (7) or less on average are counted as a failure to meet the service level.	Annually

3.15.4.2 Member and Provider Management

The Vendor will perform specific Member and Provider Management processes for the State as outlined in other sections of this document and Response Template G.2 – Functional Service Requirements.

The Vendor is to provide customer service support to AHS Staff, partner vendors and other System users. The Vendor is to maintain sufficient staff and systems to manage, track and report on Services.

The Vendor must meet the following Member and Provider Management performance standards.

Table 25. Medicaid Operations Services Service Levels – Customer Service

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
Web Portal	Claims-in-Process Real-Time Status Reporting	Post real-time status of claims-in-process on Web	Monthly
	Frequently Asked Questions (FAQ) Updates Timeliness	Update FAQs within two (2) business days of receipt of approval by the State	Monthly
	Survey Deployment Timeliness	Deploy surveys by Web portal within two (2) business days of State approval	Monthly
	Survey Reporting Timeliness	Summarize survey responses for State review within five (5) business days of completion of survey	Monthly
	Remittance Advice (RA) Web Posting Availability	Post 100% of RA concerning paid and denied claims on Web Portal immediately after claims are processed	Monthly

3.15.4.3 Operations Management

The Vendor will perform specific Operations Management processes for the State as outlined in other sections of this RFP and Response Template G.2 - Functional Service Requirements. These are primarily focused on claims processing.

An adjudicated claim is defined as a claim that requires no further adjudication or a claim suspended from adjudication processing due to error condition(s), including those errors resulting from issues outside of the Vendor's claims processing system. The calculation for claims adjudication metrics is to be based upon monthly claims volume within each measure unless otherwise noted.

The Vendor will also be responsible for loading authorization requests, performing mass adjustments and maintaining the Reference Information within the MMIS. The Vendor must meet the following Operations Management performance standards.

Table 26. Medicaid Operations Services Service Levels – Operations Management

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
Claims Adjudication	Clean Claims Adjudication Rate - Electronic Claims	Adjudicate 99% of all electronically submitted clean claims for payment or denial within two (2) business days of receipt, where "clean claim "is defined as a claim that is properly completed and contains all required data elements necessary for processing. Electronic claims are those claims submitted via the following channels: direct data entry (DDE), Web portal, and electronic batches	Monthly
	Clean Claims Entry Rate – Paper Claims	100% paper claims are scanned into the MMIS within 24 hours of receipt	Monthly
	Clean Claims Adjudication Rate - Paper Claims (98%)	Enter / process and adjudicate 98% of all clean paper claims for payment or denial within thirty (30) business days of receipt, where clean claim is "clean claim "is defined as a claim that is properly completed and contains all required data elements necessary for processing. Paper claims are those claims submitted in hard copy	Monthly

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
	Clean Claims Adjudication Rate - Paper Claims (99%)	Enter / process and adjudicate 99% of all clean paper claims for payment or denial within ninety (90) business days of receipt, where clean claim is "clean claim "is defined as a claim that is properly completed and contains all required data elements necessary for processing. Paper claims are those claims submitted in hard copy	Monthly
	Suspended Claims Finalization Rate	Finalize 100% of all suspended claims and submit to Accounts Payable for payment processing or deny within fifteen (15) days of receipt. Suspended (or "pended") claim is defined as a claim suspended from additional analysis / information, including those errors resulting from issues outside of the Vendor's claims processing system	Monthly
	Claims Error Rates	99% of all claims processed must be error free, measured through State audits and/or Member / Provider complaints	Monthly
	Claims Return	Return paper claims missing data or not meeting certain basic criteria (e.g., no provider number) to providers within 24 hours of receipt at the contractor's site, track returned paper claims daily	Monthly

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
Adjustments	Provider adjustments	Complete 100% of provider adjustments within 60 calendar days of submission.	Monthly
	TPL adjustments	Process 100% of TPL adjustments, including Medicare retro and Drug claim void requests within 30 days of receipt	Monthly
Mass Adjustments	Mass Adjustments	Perform mass adjustments within five (5) business days of the State's approval	Monthly
Authorizations	Authorization Requests – Fax	Load 100% of complete (clean) faxed Referral/Service/Treatment Plan Authorization requests into the MMIS within one (1) business day of receipt (measured as of the date stamp on the fax)	Monthly
	Authorization Requests – Paper	Load 100% of complete (clean) paper Referral/Service/Treatment Plan Authorization requests into the MMIS within one (1) business day of receipt (measured as of the date stamp on the paper)	Monthly
	Authorization Requests – Processing	After loading, 100% of authorization requests must be processed (approved or denied) within five (5) business days	Monthly
	Authorization Error Rates	99.99% of all authorization requests loaded must be error free, measured through State audits and/or Member/Provider complaints	Monthly

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
Third-Party Liability	Perform follow-up and verification of changes	Process all TPL referrals within 30 days of receipt, including updating TPL resources received through referrals from the provider community directly	Monthly
	Produce inquiry letters and mail to recipients	Perform a monthly casualty report process to identify potential Third Party Liability cases	Monthly
	Beneficiary Questionnaires	Produce and mail questionnaires to beneficiaries within 30 days of a billed or known potential TPL event/situation.	Monthly
	Mail follow-up	Produce and mail follow-up letters within 45 days from the first questionnaire mailing date	Monthly
	Process all TPL EOBs within 60 Days of receipt.	Process all TPL EOBs within 60 Days of receipt	Weekly

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
Plan Management	Plan Changes Impact Analysis	Complete impact analysis requested by the State of any changes to the Reference Information within five (5) business days of receipt of State's request	Quarterly
Timely Filing Compliance	Adjudication adjustments	Complete 100% of adjudication adjustments within 24 months from the date of service.	Annually
	Claims Processing	Properly process 100% of received claims within six months from the date of service	Annually
		The system will not process claims over 24 months from the date of service without authorization from the State	Annually
Audit Reporting	Payment Process Controls Audit	Provide an audit report of claims payment process controls and the adherence to these controls	Annually

3.15.4.4 Financial Management

The Vendor will perform specific Financial Management processes for the State as outlined in other sections of this document and Response Template G.2 – Functional Service Requirements.

The Vendor is responsible for timely and accurate MMIS payment and collection activities. The Vendor must meet the following Financial Management performance standards.

Table 27. Medicaid Operations Services Service Levels – Financial Management

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
Claims Payment	Payment Cycle Schedule	Run at least one (1) payment cycle weekly based on release criteria entered by the State. Failure to meet the defined threshold one or more weeks in the defined month constitutes failure to achieve for the full month.	Monthly
	Notification of Overpayment	Provide the State written notification within 48 hours of discovery of any overpayments, duplicate payments, or incorrect payments (regardless of cause).	Monthly
	Rejected Claim File Reporting Timeliness	Report rejected electronic claim files back to the submitter within one (1) working day of receipt.	Monthly
	Payment Cycle Reporting Schedule	Provide payment cycle reports to the State by 8:00 a.m. on the day of the payment processing cycle.	Monthly
Funds Management	Receivables Processing	95% of all outstanding receivables are collected within 30 days.	Quarterly
	Bank Reconciliation	Produce monthly bank reconciliation report Including general ledger and trial balance that reconciles to the bank statement.	Monthly
	Check Logging	Log all checks into MMIS for deposit within 24 hours of receipt	Weekly
	Check Deposit	Deposit incoming checks into a specified account within 24 hours of receipt	Weekly
	Cash Disposition	Disposition all cash receipts within 45 days of deposit into the MMIS account	Weekly

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
	Mail Follow-up – 30 days	Send initial letter via USPS mail to providers when account receivables age 30 days.	Monthly
	Mail Follow-up – 60 days	Send second letter via Certified USPS mail to providers when account receivables age 60 days.	Monthly
Reporting	1099 Federal Reporting Schedule	1099 must be mailed to all Providers by January 31.	Monthly

3.15.4.5 Data Analytics

The Vendor will perform specific Data Analytics processes for the State as outlined in other sections of this document and Response Template G.2 – Functional Service Requirements.

In addition to providing a wide range of Data Analytics functions for Medicaid and AHS by conducting data analysis and producing reports to inform the State's decision-making process, the Vendor is responsible for supporting the State's Program Integrity activities. The Vendor must meet the following Data Analytics performance standards.

Table 28. Medicaid Operations Services Service Levels – Data Analytics

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
Reporting	Scheduled Reports with Analysis	Prepare and deliver pre-defined reports, at the agreed upon due date, to the State on schedule 100% of the time.	Quarterly
	Ad-hoc Reports	Refresh data available to the State for ad-hoc reporting at the agreed upon schedule 100% of the time	Quarterly
Data Analysis	MMIS Data Analysis	Complete data analysis requested by the State within five (5) business days of receipt of State's request.	Quarterly

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
Program Integrity	Fraud, Waste and Abuse	Inform the State of suspected fraud, waste and abuse within 2 business days of identification. Fraud, waste and abuse reports submitted should contain as much information as possible.	Monthly

3.15.5 Contact Center Service Level Requirements

The Contact Center Vendor will perform specific Contact Center processes for the State as outlined in other sections of this RFP and Response Template G.3 – Functional Service Requirements.

The Vendor is to provide direct customer service support to Providers and Members. The Vendor is to maintain sufficient staff and systems to manage, track and report on Services via multiple channels including telephone, Interactive Voice Response System (IVRS), Web portal, email and mail. The Vendor must provide an integrated contact management system to be used in tracking and managing customer (i.e., Providers and Members) contacts from all channels, and can report on customer contact metrics by channel or comprehensively. The Vendor and the State will together analyze the inquiries received monthly to identify opportunities to decrease the volume of the inquiries and improve the efficiency and effectiveness of the responses.

3.15.5.1 General Service Level Requirements

The Contact Center Vendor must provide the following levels of Service.

Table 29. Contact Center Service Levels – General Services

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF MEASUREMENT
Compliance	Compliance with Federal and State standards including, but not limited to HIPAA and ACA.	The operations and processes must meet all HIPAA, Federal and State standards.	Quarterly
Reporting	Delivery of weekly and monthly status reports	100% weekly and monthly written status reports are delivered by the agreed day/date	Monthly

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF MEASUREMENT
Documentation	Update all System and process documentation when approved by the State	Documentation updates are delivered within 5 workdays of State approval of implementation of the change	Monthly
Staffing	Fill vacant positions with staff within the agreed timeframe	Vacant positions are filled with staff of equal ability and qualifications within 30 calendar days of initial vacancy.	Monthly
Change Requests	Report on change requests	100% of change requests are tracked and reported to the State with: • Weekly progress reports with the current status of system changes. • Monthly summary report with lists of all completed and outstanding change requests with estimated personnel hours to complete them, by status and priority.	Weekly / Monthly
	Document change requests	A written response to 100% of change requests within five (5) workdays of receipt of the change request with a clear and complete description of the change request, assessment of any perceived problems that may impact operations, constraints, assumptions, targeted completion date and effort to complete	Monthly
	Complete Change System Requests (CSRs) in a timely manner	Complete 100% of CSRs by the agreed target date	Monthly

3.15.5.2 Member and Provider Management Service Level Requirements

The Vendor must meet the following Member and Provider Management performance standards.

Table 30. Contact Center Service Levels – Member and Provider Services

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
IVRS	IVRS Availability	IVRS is available seven-days-per-week, 24-hours-per-day excluding State-approved downtime.	Weekly
	Timely Connection Rate	Callers are connected with the IVRS within three (3) rings for 99% of all daily calls	Weekly
	Dropped Call Rate	Dropped call rate shall not exceed 1% of the total daily call volume, where dropped call refers to unexpected disconnection of the call	Weekly
	Script Update Timeliness	Updates to the IVRS recorded messages/prompts/responses and call center representative scripts shall be made within two (2) business days of receiving a request from the State, unless otherwise directed by the State	Weekly
	IVRS Call Abandonment Rate	Lost call abandonment rate after the call exits the IVRS shall not exceed 5%	Weekly

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
Call Center	Average Speed of Connection to Live Representative	During open hours, for the first year of the Contract, 70% of all incoming calls that opt to talk to a Customer Service Representative (CSR) are answered by a CSR within 25 seconds of leaving the IVRS. For the second year of the Contract, the requirement will be 70% of calls are answered within 20 seconds of leaving the IVRS. Beginning the third year of the Contract, the requirement will be 80% of calls are answered within 20 seconds of leaving the IVRS.	Weekly
	Ring Busy Rate	0% of incoming calls are to ring busy	Weekly
	Call Abandonment Rate	Call abandonment rate not to exceed 5% of the total daily call volume, where abandonment is defined as caller hang-up before a live representative is reached	Weekly
	Daily Average Hold Time	Average hold time is to be less than two (2) minutes for at least 90% of all calls and three (3) minutes for 95% of the total daily call volume, where hold time is defined as the time elapsed before response by a live representative after call is initially triaged and handed off to a customer service representative	Weekly

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
	Daily Maximum Hold Time	Maximum hold time is not to exceed 8 minutes, per call, for 100% of calls each day. This includes all hold time experienced during the call, where hold time is defined above	Weekly
	Accuracy Rate	Monthly accuracy of responses to Call Center inquiries is to be at least 90%, based on a sampling of all calls monitored using a process established by the State and the Vendor	Weekly
Web Portal	Claims-in-Process Real-Time Status Reporting	Post real-time status of claims-in-process on Web	Monthly
	Frequently Asked Questions (FAQ) Updates Timeliness	Update FAQs within two (2) business days of receipt of approval by the State	Monthly
Provider Inquiry	Faxed Inquiry Response Timeliness	Respond to 100% of faxed Provider inquiries within three (3) business days of receipt (measured as of the date stamp on the fax)	Monthly
	Electronic Inquiry Response Timeliness	Respond to 100% electronic Provider inquiries (including email and Web portal submissions) within one (1) business day of receipt	Monthly
Provider Enrollment	Enrollment Packet Distribution Timeliness	Mail 100% of Provider enrollment packets within two (2) business days of successful Provider enrollment	Monthly
	Provider Information Update Timeliness	Enter 100% of changes to Provider information within two (2) working days of receipt of the input from a State-authorized entity	Monthly

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
	Application Processing Timeliness	100% of complete (clean) Provider applications are processed, including entry of all Provider information, within five (5) business days of receipt for low risk Providers or fifteen (15) business days for moderate or high risk Providers (regardless of media of application -- paper, electronic).	Monthly
	Enrollment Decision Letter Distribution Timeliness	100% of approval or denial notification letters are mailed to Providers within one (1) business day of completing application processing.	Monthly
Provider Re-Certification	Re-Certify Providers	Annually: Providers are recertified on the recertification date.	Annually
Provider Training	Provider Training Plan	An Annual Provider Training Plan is Created	Annually
Member Inquiry	Phone Inquiry Response Timeliness	100% of verbal (telephone) Member inquiries are responded to within one (1) business day of receipt	Monthly
	Written Inquiry Response Timeliness	at least 90% of written Member correspondence is responded to within five (5) business days of receipt	Monthly
	Electronic Inquiry Response Timeliness	100% of electronic) Member inquiries (including email and Web portal submissions) are responded to within one (1) business day of receipt	Monthly
Provider Publications	Provider Relations Plan	A comprehensive provider relations / communications plan is produced for review and approval by the State	Quarterly

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
	New/Updated Publication Distribution Timeliness	New publications and publications with extensive changes are produced in final approved form and distributed no more than 30 calendar days from the date of the State written request for the new or updated publication.	Monthly
	Newsletter Publishing Schedule	Quarterly newsletters are published	Quarterly
	Requested Materials Distribution Timeliness	Provider manuals and updates or bulletins are distributed within three (3) business days of receipt of a request from a Provider.	Monthly
	Web Portal Update Timeliness	Updates are published on the Provider website within one (1) business day of the date of State written approval for publication.	Monthly
	Web Portal New/Updated Publication Posting Timeliness	All new or updated Provider manuals are announced and made available via website, for download and printing by the Provider, within three (3) business days of written approval by the State.	Monthly
	RA Message Timeliness	100% of Remittance Advice (RA) messages are published within one (1) payment cycle from the date of State approval of the message.	Monthly
Member Publications	New/Updated Publication Distribution Timeliness	Updates to publications are prepared and delivered in final form to the State for review and approval within three (3) business days of the State's request or the date changes proposed by the Vendor were approved by the State.	Monthly

SLR NAME	SERVICE LEVEL REQUIREMENT	SERVICE LEVEL REQUIREMENT DEFINITION	FREQUENCY OF SLR MEASUREMENT
	Web Portal Update Timeliness	Updates are published on the Member website within one (1) business day of the date of State written approval for publication.	Monthly
Reporting	Weekly Reporting	Weekly Member and Provider contact statistics are published to include at a minimum the following data elements: o AVR Calls Received o PSU Calls Received o PSU Calls Answered o PSU Calls Out o PSU Calls Answered + Out (sub-total) o Average Daily Calls o % Abandon o Average TTA Seconds o Average Length o Longest Wait o % Answered < 2 min. o % answered < 3 min. o Complaints	Weekly

3.16 Proposed Project Organizational Approach

The MMIS is part of the broader Medicaid Operations Solution Procurement, which in turn is part of the Health Services Enterprise, described previously. There is a well-defined governance structure that provides direction and oversight to ensure that decisions are made effectively and efficiently, and that the project and ongoing operations both have the resources required for success. The Vendor must operate within the Project governance structure, as well in the HSE Program governance structure.

The sections below outline the responsibilities for the separate organizations that are known to interact in this Project.

3.16.1 Project Staffing

3.16.1.1 State of Vermont Project Roles and Responsibilities

The State MMIS Project team will coordinate overall project management responsibilities including the availability of State resources as required to support tasks and retain acceptance and approval authority. Specifically, during the design, implementation and initial M&O phases until System Acceptance the State will:

- Define the goals and objectives of the MMIS/CC implementation Project and ongoing program
- Communicate the goals and objectives of the Project and program to all stakeholders
- Oversee the project management approach that will govern the Project
- Assist with the response planning and resolution of risks and issues identified.
- Review the draft deliverables and final deliverables developed by the Vendor and provide feedback and required changes for the Vendor to make until the State is satisfied with the resulting deliverable
- Approve final deliverables developed and revised by the Vendor
- Provide access to State management and Subject Matter Experts (SMEs) for the approval of the deliverables required to meet the goals and objectives of the Project
- Monitor Vendor performance according to contractual obligations, provide improvement requests, and approve invoices as detailed in the final Contract

Key State Roles are listed below -

- **MMIS Executive Sponsor(s):** Responsible for the highest level of program review and approval
- **MMIS Steering Committee:** Responsible for approving Contract change orders prior to execution by the State Procurement Office
- **MMIS State Project Manager(s):** Responsible for the oversight and monitoring the activities and deliverables of the Vendor and the State team. The Project Manager will act as the primary point of contact for obtaining State resources required for the Project. The Project Manager shall be responsible for the overall coordination of the State / Vendor Project Team, for ensuring they both comply with the project governance and the reporting structure, develop response plans to identified risk in areas that require State involvement, and that issues are tracked and resolved, either

through direct resolution with the Vendor's Project Manager or through the defined escalation process.

- **DII Technical Oversight:** Responsible for the architecture and technical direction, oversight, monitoring and approval of the MMIS/CC
- **HSE Program Management Office:** Responsible for ensuring the successful implementation of the Project, as well as providing program-level oversight for the HSE. The HSE PMO will review Project artifacts in relation to applicability to and reuse by other solutions and will manage the project scope and HSE Implementation Advanced Planning Document (IAPD) budget. The HSE PMO reports to the HSE Operations Steering Committee consisting of HSE projects' leadership, and to the HSE Executive Committee, consisting of AHS and State leadership

If the Vendor believes that certain work will be performed by the State's MMIS team or functional experts, and that work is not included in the Vendor's firm fixed price, the Vendor must identify the nature and associated hours of that work in an attachment to the Cost Proposal.

3.16.1.2 Vendor Roles and Responsibilities

The Vendor will provide the resources to complete the following activities:

- Prepare, submit and obtain approval for individual project management approaches and plans
- Execute and maintain individual project management approaches and plans
- Prepare and submit the draft deliverables for State review and comment in accordance with the Project Work Plan
- Prepare and submit the final deliverables for State review and approval in accordance with the Project Work Plan
- Abide by the goals, objectives and requirements contained in this RFP and the resulting Contract
- Prepare and conduct requirements confirmation sessions with all necessary State management, SMEs and other designated vendors
- Prepare and submit to the State for approval the project management plans for meeting the goals and objectives of the MMIS and/or Contact Center solution
- Manage all activities defined in the approved project management plans

- Submit for review and approval all changes to the approved project management plans
- Participate with other designated vendors (such as the existing claims processing vendor), State management and SMEs in the creation of the MMIS and/or Contact Center integrated project management plan
- Review and confirm roles and responsibilities of the prime and sub Vendor(s) and those that are the responsibility of other vendors or the State
- Collaborate with the State and other designated vendors to define quality measures to monitor and manage the required service level objectives outlined in this RFP
- Manage all business processes using a continual improvement approach and submit improvements to the State for review and approval
- Comply with all laws, policies, procedures and standards dictated by the State in meeting the goals and objectives of the MMIS and/or Contact Center solution
- Provide an estimate of the number and type of State resources required

It is the Vendor's responsibility to warrant that the Vendor and its principals are eligible to participate in all work and transactions and have not been subjected to suspension, debarment, or similar ineligibility determined by any federal, state or local governmental entity and that the Respondent is in compliance with the State of Vermont statutes and rules relating to procurement and not listed on the federal government's terrorism watch list as described in Executive Order 13224. Entities ineligible for federal procurement are listed at http://www.epls.gov.

3.16.1.2.1 ***Vendor Key Project Personnel Roles***

The term "Key Project Personnel," for purposes of this procurement, means Vendor personnel deemed by the State as being both instrumental and essential to the Vendor's satisfactory performance of all requirements contained in this RFP. The State expects that these Key Project Personnel identified to support each phase will be engaged during their respective phases. The State will consider suggestions for alternative alignment of duties within the submitted Proposal. Changes to the proposed positions and responsibilities will only be allowed with prior written permission from the State, unless a specific exemption is granted. If the Vendor believes that an alternative organizational design could improve service levels or decrease costs, discuss these options and their benefits within the response templates for this RFP.

Key Project Personnel are to be full-time and dedicated solely to the Vermont Medicaid account unless the Vendor provides alternative solutions that meet State's approval.

The Vendor must include names and resumes for proposed Key Project Personnel as part of its Proposal. The Vendor must ensure Key Project Personnel have, and maintain, relevant current license(s) and/or certification(s).

The following table provides Key Project Personnel positions, corresponding roles and responsibilities for the Project, and minimum qualifications for each, regardless of the component of this RFP that the Vendor is bidding on. Additional Key Project Personnel for the MMIS and Contact Center components of this RFP are included in following subsections. Other positions may be proposed at the Vendor's discretion.

The Vendor must propose an engagement and partnership model with the State's MMIS team to ensure proper knowledge transfer throughout the life of the Project. This will include "shoulder-to-shoulder" work with State resources so that the State staff becomes familiar with the design, development and implementation of the System. This structure must provide a shoulder-to-shoulder partnership with key Vendor and State staff, for example: Architect; Business Analyst and Functional Lead; Database Administrator; Help Desk Specialist.

The Vendor should propose a structure that will best meet this requirement. The final configuration of this organizational structure requirement will be defined during Project Initiation and Planning.

Table 31. Vendor Key Project Personnel Roles

TITLE	ROLES AND RESPONSIBILITIES	EXPECTED QUALIFICATIONS
Account Director	The Account Director: • Serves as the primary point of contact with the State's Contract Administrator, MMIS Director and other State Executive Sponsors for activities related to contract administration, overall project management and scheduling, correspondence between the State and the Vendor, dispute resolution, and status reporting to the State for the duration of the Contract • Is authorized to commit the resources of the Vendor in matters pertaining to the implementation performance of the Contract • Is responsible for addressing any issues that cannot be resolved with the	Minimum of five (5) years direct project oversight and authority over projects in excess of 10 million dollars Special consideration will be given to those who have previously managed MMIS accounts that have included both DDI and Operations, and who have experience working with HIPAA privacy and security rules

	Vendor's Project Manager • Is responsible for all subcontractor relationships	
Account Manager	The Account Manager: • Serves as a liaison with the State during the entire Contract • Is available and responsive to State requests for consultation and assistance • Attends, upon request, meetings and hearings of Legislative Committees and interested governmental bodies, agencies, and officers • Oversees the MMIS Replacement DDI and Certification • Is responsible for establishing and maintaining a positive client relationship. Provides timely and informed responses to operational and administrative inquiries that arise • Delegates authority to the Deputy Account Manager when not able to be available • Meets with AHS staff or such other person the State may designate on a regular basis to provide oral and written status reports and other information as required • Manages the relationships with subcontractors and partner vendors	A total of eight (8) years of demonstrated experience in: • Management of an organizational unit within a Medicaid Agency in a state or other US territory; and/or • Management of an organizational unit within a Medicaid Fiscal Agent which is performing operations in a state of equivalent scope to Vermont; and/or • Experience in other large health care claims processing organization Preference given to candidates with Medicaid Fiscal Agent operations experience
Application Manager	The Application Manager: • Is responsible for managing all configuration activities for modifications and enhancements as described below ○ Modifications include, but are not limited to: routine system maintenance, changes in rate or fee schedules, and changes required to remain compliant with Federal regulations and standards	Five (5) years of MMIS experience Highly knowledgeable in quality assurance/control procedures, strong documentation and reporting background, demonstrated proactive problem management skills, and experience with change and incident management Preference will be given to candidates with implementation experience in the system/application being bid

	○ Enhancements include, but are not limited to: changes initiated by the State to achieve strategic objectives, implement new programs, and mature business capabilities	
Systems Manager	The Systems Manager: • Is responsible for planning, developing, testing, implementing, and maintaining the Vermont MMIS as well as assisting with management of the MMIS Replacement DDI and Certification	A total of eight (8) years of demonstrated experience that can consist of any combination of the below: • Manager of an organizational unit within a Medicaid Agency in a State or other US territory; and/or • Manager of an organizational unit within a Medicaid Fiscal Agent which is performing operations in a State or other US territory; and/or • Experience in another large health care claims processing organization
EDI Manager/ Web Portal Manager	The EDI Manager/Web Portal Manager: • Oversees Electronic Data Interchange activities, provides support for HIPAA transaction compliance, and develops and maintains implementation guides • Supports expanding health information initiatives including, but not limited to: HIE and ePrescribing	A total of five (5) years of demonstrated experience as follows: • Three (3) years of which should be in the development, implementation and/or support of EDI functionality within a Medicaid Agency and/or Medicaid Fiscal Agent in a State or other US territory; and/or • Development, implementation and/or providing operational support for ongoing HIPAA transaction compliance for a large health care claims processing organization; and/or • Development and/or support of policies, processes and/or procedures for the review and maintenance of implementation guides Preference given to candidates with Medicaid Fiscal Agent operations experience
Project	The Project Manager:	Current PMP certification from the Project

Manager	• Provides onsite management of the Project and is the chief liaison for the State during both DDI and initial M&O activities • Is authorized to make day-to-day Project decisions • Is responsible for facilitating the Project by using the project management processes, organizing the Project, and managing the team work activities consistent with the approved work plan • Is responsible for scheduling and reporting Project activities, coordinating use of personnel resources, identifying risks and issues and solving problems, and facilitating implementation of the System • Is expected to host bi-weekly onsite status meetings, monthly milestone meetings, as well as interim meetings • Assigns Vendor staff to the above meetings as appropriate • Develops and distributes an agenda and minutes for each meeting • Provides expert guidance ensuring that MMIS policies, business rules, and requirements as defined by the State are correctly implemented in the Vendor's Solution • Advises the State regarding best practices and recommends modifications to business processes, which improve the overall MMIS operations • Develops and maintains thorough project planning documentation that includes (but not limited to) Project Management Plan and fully resourced project schedule. • Immediately notify State PM on any deviation from agreed upon scope, schedule, budget, or level of quality.	Management Institute A total of five (5) years of demonstrated experience in: • Project Management of a project that encompassed the full system development life cycle from initiation through post implementation within a Medicaid Agency in a State or other US territory; and/or • Account management for a government or private sector health care payer, including a minimum of three (3) years of Medicaid systems experience in a state similar in scope and size to Vermont Preference given to candidates with Medicaid Fiscal Agent operations experience

Quality Manager	The Quality Manager: • Oversees all quality assurance functions and responsibilities including deliverable review, accuracy of reports, system enhancement documentation, and review of test results	A total of four (4) years of demonstrated experience as follows: • Experience working for a Medicaid Fiscal Agent or experience with a large health care organization • All four years' experience are in development and maintenance of a vigorous ongoing quality control function that encompasses data entry, verification of systems outputs, balancing of jobs, validating the integrity of the data, controlling and accounting for systems inputs, provider communications, finance and accounting, and ensuring adequate internal controls and quality checks throughout all system and operations tasks

3.16.1.2.1.1 MMIS Vendor Key Project Personnel Roles

The following table describes additional Key Project Personnel that are required for the MMIS component of this RFP.

Table 32. Vendor Key Project Personnel Roles

TITLE	ROLES AND RESPONSIBILITIES	EXPECTED QUALIFICATIONS
Deputy Account Manager/ Operations Manager	The Deputy Account Manager/Operations Manager: • Fills the role of Account Manager in that person's absence • Plays an active role in day-to-day management of the Account so as to be knowledgeable and aware of all issues, concerns and requirements • Manages staff assigned to all operational business activities, day-to-day operations of the MMIS and Fiscal Agent operations	Any combination of five (5) years of Medicaid operations or Medicaid Fiscal Agent operations experience or other large health care claims processing organization Preference given to candidates with Medicaid Fiscal Agent operations experience

	• Assists with oversight of the MMIS DDI, Certification and Operations	
Claims Manager	The Claims Manager: • Is responsible for the coordination of all operational activities related to claims processing • Manages the operational claims activities for the Vendor • Ensures that performance standards are met in accordance with the (SLA) • Coaches team to meet and/or exceed performance goals • Responsible for internal and customer initiated audits and regulatory reviews	3 to 5 years experience in healthcare, managed care or insurance industry environment required Previous claims management experience required Strong preference to hold a Certified Professional Coder (CPC) credential. If this is not held, must achieve this within one year of beginning work
Financial Manager	The Financial Manager: • Manages all financial functions, reporting including daily, monthly and other cyclical financial processes, and supports the budget process	BA/BS or higher in a relevant field A total of five (5) years' experience as follows: • Managing an organizational department or unit responsible for the accounting, budget; and/or • Reporting function of a large commercial health care claims processing organization, Medicaid agency, or a similar government project Preference given to candidates with MMIS

		financial management and accounting experience
Reporting and Analytics Manager	The Reporting and Analytics Manager: • Is responsible for managing report development and analysis • Recommends establishment of new or modified reporting methods and procedures to improve report content and completeness of information • Confers with persons originating, handling, processing, or receiving reports to identify problems and to gather suggestions for improvements • Examines and evaluates purpose and content of business reports to develop new, or improve existing format, use, and control • Reviews reports to determine basic characteristics, such as origin and report flow, format, frequency, distribution and purpose or function of report • Evaluates findings, using knowledge of workflow, operating practices, record retention schedules • Prepares and issues instructions concerning generation, completion, and distribution of reports according to new or revised practices, procedures, or policies of reports management	A total of four (4) years of demonstrated experience in: • Development, implementation and/or analysis of reports utilized in the support and/or operations of a Medicaid Agency in a State or other US territory; and/or • Development, implementation and/or analysis of reports utilized in the support and/or operations of a Medicaid Fiscal Agent which is performing operations in a State of equivalent scope to Vermont; and/or • Development, implementation and/or analysis of reports utilized in the support and/or operations of a large health care claims processing organization; and/or • Development, implementation and/or monitoring of policies, processes and/or procedures and/or documentation for report development, generation, review and/or loading into a production reports database platform Preference given to candidates with Medicaid Fiscal Agent operations experience

Additional Vendor Staff Roles for the MMIS Solution

The State expects the Vendor to propose a staffing model to achieve the Project and service delivery roles. The following list provides a guideline for the various Vendor staff roles the Vendor may propose to support the Project:

- Architect
- Business Analyst/Functional Lead
- Change Management Lead
- Communication/Network Specialist
- Database Administrator
- Database Designer
- Help Desk Specialist
- Hardware Specialist
- Operations Lead/Manager
- Project Director
- Project Manager
- Programmer
- Quality Assurance Manager
- Security System Engineer
- Systems Administrator
- Technical Writer
- Test Lead/Manager
- Tester
- Training Lead/Manager
- Training Specialist
- Certified Professional Coder
- Utilization Review Specialist

- Reference Analyst
- Data Entry Specialist
- Third Party Liability Specialist
- Reporting Specialist
- Claims Processing Specialist

3.16.1.2.1.2 Contact Center Vendor Key Project Personnel Roles

The following table describes additional Key Project Personnel that are required for the Contact Center component of this RFP.

Table 33. Vendor Key Project Personnel Roles

TITLE	ROLES AND RESPONSIBILITIES	EXPECTED QUALIFICATIONS
Operations Manager	Operations Manager: • Fills the role of Account Manager in that person's absence • Plays an active role in day-to-day management of the Account so as to be knowledgeable and aware of all issues, concerns and requirements • Manages staff assigned to all operational business activities, day-to-day operations of the MMIS and Fiscal Agent operations • Assists with oversight of the MMIS DDI, Certification and Operations	Any combination of five (5) years of Medicaid operations or Medicaid Fiscal Agent operations experience or other large health care claims processing organization Preference given to candidates with Medicaid Fiscal Agent operations experience

Provider/ Member Services Manager	The Provider/Member Services Manager: • Oversees Provider enrollment, Provider/Member relations, Provider training and outreach and associated Help Desk business areas	Three (3) years' experience with a Medicaid Fiscal Agent or other large health care claims processing organization performing Provider/Member services (e.g., enrollment and Provider/Member relations activities), developing and implementing training, communications, outreach programs for a Medicaid Fiscal Agent or private sector health care payer

Additional Vendor Staff Roles for the Contact Center Solution

The State expects the Vendor to propose a staffing model to achieve the Project and service delivery roles. The following list provides a guideline for the various Vendor staff roles the Vendor may propose to support the Project:

- Architect
- Business Analyst/Functional Lead
- Change Management Lead
- Communication/Network Specialist
- Database Administrator
- Database Designer
- Help Desk Specialist
- Hardware Specialist
- Project Director
- Project Manager
- Programmer
- Quality Assurance Manager
- Security System Engineer
- Systems Administrator
- Technical Writer

- Test Lead/Manager
- Tester
- Training Lead/Manager

3.16.2 Location of Contracted Functions and Personnel

The Vendor will secure and manage office space in reasonable proximity (10 miles) to the DVHA primary location (currently Williston, Vermont) to maintain a productive work environment and for the convenience of the State to allow State personnel to hold meetings and other business activities. The Vendor will be responsible for moving offices if the DVHA primary location changes. The State expects the Vendor to recommend the specific locations for their proposed staffing model. Vendor managerial staff must be available to participate in project-related meetings as scheduled by the State.

All Contact Center staff providing direct member or provider support must be located in the State of Vermont.

3.16.3 Vendor Organizational Change Management

The Vendor shall seek and receive State approval before hiring or replacing any Key Project Personnel. The Vendor shall remove and replace Key Project Personnel, if requested by the State, within two (2) weeks of the request for removal.

The Vendor must provide the State with written notification of anticipated vacancies of Key Project Personnel within two (2) business days of receiving the individual's resignation notice, the Vendor's notice to terminate an individual, or the position otherwise becoming vacant. Replacements for Key Project Personnel shall have qualifications that meet or exceed those specified in this section and will be subject to approval by the State. The Vendor shall provide the State with status update reports every thirty (30) days on the progress of the replacement candidate recruiting process until a qualified candidate is hired. The Vendor shall have in place a qualified replacement within sixty (60) days of the last day of employment of the departing Key Project Personnel. During the recruitment and training period, the Vendor shall provide an interim replacement for all Key Project Personnel, subject to approval by the State.

3.17 Proposed Project Schedule

The State anticipates the awarded Vendor will begin work on the Project, by February 3, 2015. The State anticipates that full operations will begin January 1, 2017. The State expects that the Vendor will work with the incumbent vendor to ensure that there is no disruption of service during the implementation and transition periods.

Table 34. Project Schedule Key Schedule Constraints

DATE	CONSTRAINT
February 3, 2014 (Anticipated Kick-Off)	Expected Vendor(s) start date.
June 30, 2015	Expiration of call center contract; Vendor must have Contact Center systems and services operational by this date
January 1, 2017	Vendor must have all systems and services operational by this date

3.18 Implementation Phasing

The State anticipates that a phased implementation of functional components will be required to manage risk and level resources.

The Vendor must identify the proposed schedule and functional requirements that will be delivered in a more detailed set of implementation phases that will enhance likelihood of successful implementation using their methodologies, systems, and services. External facing capabilities, such as the Provider contact center, need to be prioritized to ensure consistency for these stakeholders. All phasing must meet the dates listed in this RFP. Requested exceptions to these dates must be described in the responses to this RFP.

3.19 Scope of Work

The following sections define the application DDI services, M&O services, and the application warranty services that are required for the proposed MMIS solution and the Contact Center solution. The scope of work and Service Level Requirements for ongoing operational services are identified in other sections of this RFP.

The services are applicable to the scope information provided earlier in this Section regarding the Functional Requirements, Non-Functional Requirements and the proposed solution architecture.

3.19.1 Deliverables Expectations Document

The Vendor shall develop each Project Deliverable in accordance with a Deliverable Expectations Document (DED) agreed to by the State and the Vendor and approved by the State. No work shall be performed on any deliverable until the DED has been approved in writing by the State.

3.19.2 Deliverables Submission

All Vendor deliverables are subject to the State's approval. The process for deliverable submission follows:

- The Vendor will submit the deliverable for review by the State, including a copy of the approved DED for that deliverable
- The State will review the deliverable
  - If the deliverable does not meet the requirements outlined in the Scope of Work and DED to the satisfaction of the State, the State will reject the deliverable in writing and specify the changes required for acceptance
  - If the deliverable is rejected, the Vendor will revise the deliverable to meet all Scope of Work and DED requirements and resubmit for review by the State; this process will continue until the deliverable meets the State's expectations and Scope of Work and DED requirements
  - If a deliverable re-submitted by the Vendor continues to fail to meet any DED requirement, the State may, at its option, collect Liquidated Damages from the Vendor
- If the Deliverable meets the Scope of Work and DED requirements to the satisfaction of the State, it will be formally accepted by the State as described in the following section

3.19.3 Acceptance

All Vendor deliverables are subject to State review prior to final acceptance and payment.

Acceptance of all Vendor deliverables will be completed via a Deliverables Acceptance Document provided by the State.

The State will have ten (10) working days to complete its review of each deliverable unless otherwise specified in the Scope of Work or DED. However, this expectation will not in any way replace formal acceptance of any deliverable. The State will accept or reject the deliverables in writing via a Deliverables Acceptance Document. Deliverables will only be deemed accepted if the State indicates the acceptance through a Deliverables Acceptance Document. In the event of rejection, the Vendor shall have five (5) working days (or a longer period, if approved in writing by the State) to correct the rejected deliverable and resubmit it to the State. Failure to complete a rejected deliverable within the allotted time, or failure for a re-submitted deliverable to meet the requirements stated in the Scope of Work or associated DED, shall entitle the State to collect Liquidated Damages.

The Vendor shall track the status of all submitted Deliverables using a tracking sheet or tool provided by the Vendor and approved by the State.

3.19.4 Controlled Correspondence

In order to track and document requests for decisions and/or information, and the subsequent response to those requests, the State and the Vendor shall use Controlled Correspondence.

Each Controlled Correspondence document shall be signed by the State Project Manager (or designee) and the Vendor Project Manager (or designee). No Controlled Correspondence document shall be effective until the signatures of both are attached to the document.

The Controlled Correspondence process may be used to document mutually agreeable operational departures from the specifications and/or changes to the specifications. Controlled Correspondence may be used to document the cost impacts of proposed changes, but Controlled Correspondence shall not be used to change pricing.

Controlled Correspondence shall not be the basis of a claim for equitable adjustment of pricing. Any changes that involve a change in pricing must be made through the Project Change Control process and must be documented in a Purchase Order Change Notice signed by the State and the Vendor.

Controlled Correspondence documents will be maintained by both parties in on-going logs and shall become part of the normal status reporting process.

3.19.5 List of Deliverables

3.19.5.1 Recurring Project Deliverables

The following table provides a list of recurring deliverables that will be created by the Vendor during the life cycle of the Project execution. All contracted Vendors will be required to create the following deliverables.

Table 35. Recurring Deliverables

TASK	DELIVERABLE
Task 0 - Project Monitoring and Status Reporting	Deliverable 0 - Project Status Reporting (Recurring throughout the length of the Project, including DDI and M&O)

3.19.5.2 *Task Related Deliverables*

The following table provides a list of deliverables that will be created by the Vendor during implementation and M&O. These deliverables are defined in the Section entitled Detailed Scope of Work. The State requires Vendors to use PMI based methodology and industry best practices for project management and describe their recommended approach. All contracted Vendors will be required to create the following deliverables.

Table 36. Task Related Deliverables

TASK	DELIVERABLE	PAYMENT MILESTONE
Task 1 – Project Initiation and Planning	Deliverable 1 – Project Kick-off Presentation	
	Deliverable 2 – Project Management Plan including sub-component plans (i.e. Risk Mgmt Plan)	
	Deliverable 3 – Project Work Plan and Fully Resourced Schedule	X
	Deliverable 4 – Requirements Analysis, System Design and Development Strategy	
	Deliverable 5 – System Implementation Strategy	
	Deliverable 6 – Master Testing Strategy	
	Deliverable 7 – Requirements Traceability Plan	
Task 2 – Requirements Analysis and System Design	Deliverable 8 – Functional Specification and System Design Document	X
	Deliverable 9 – Data Integration and Interface Design Document	X
	Deliverable 10 – System Architecture	X
	Deliverable 11 – Technical Design Document	X
Task 3 – System	Deliverable 12 – System Implementation Plan	

TASK	DELIVERABLE	PAYMENT MILESTONE
Configuration and Development	Deliverable 13 – Data Integration and Synchronization Plan	
	Deliverable 14 – System Maintenance Support Plan	
Task 4 –Testing	Deliverable 15 – Test Plan	X
	Deliverable 16 – Test Scenarios, Test Cases and Test Scripts	
	Deliverable 17 – Documented System Test Results	
Task 5 – Training	Deliverable 18 – Training Plan	X
	Deliverable 19 – Training Manuals, End-User Guides and Materials	X
	Deliverable 20 – Documented Evidence of Successful End-User Training	X
	Deliverable 21 – Operations Quality Plan	
Task 6 – Deployment	Deliverable 22 – Deployment Plan	
	Deliverable 23 – CMS Certification Planning	X
	Deliverable 24 – System Incident and Defect Resolution Report	X
	Deliverable 25 – Completed Detailed Functional and Technical Specifications Traceability Matrix	X
	Deliverable 26 – System Source Code and Documentation	X
	Deliverable 27 – Performance SLAs	
Task 7 – Phase Closeout	Deliverable 28 – Phase Closeout	X

TASK	DELIVERABLE	PAYMENT MILESTONE
Task 8 – System M&O	Deliverable 29 – System Incident Reports – M&O	X
	Deliverable 30 – Adaptive Maintenance Reports	X
	Deliverable 31 – System Enhancement Reports	X
	Deliverable 32 – Service Desk Support Plan	X

3.19.5.3 Service Related Deliverables

The following table provides a list of service deliverables that will be performed by the Vendor. All contracted Vendors will be required to create the following deliverables.

Table 37. Operational Phase Deliverables

CATEGORY	DELIVERABLE	REPORTING FREQUENCY	PAYMENT MILESTONE
Routine Operations	Deliverable 33 – Monitoring the implemented system(s)	Weekly	
	Deliverable 34 – Weekly reporting of any problem identified	Weekly	
	Deliverable 35 – Monthly Status Reports	Monthly	X
CMS Certification	Deliverable 36 – CMS Certification Documentation	TBD	
	Deliverable 37 – CMS Certification Electronic Document Storage	TBD	

3.19.6 Detailed Scope of Work

The following sections define the application DDI services, M&O services, and the application warranty services that are required for the proposed MMIS solution and the proposed Contact Center solution. This section also includes a description of the business operations support services the Vendor will deliver for the State.

While the transition to Green Mountain Care as universal coverage for all Vermonters is not specifically in the scope of this RFP, all applicable deliverables in this section should address and discuss the implication of this transition, currently planned for 2017, including schedule and scope constraints and impacts of the System and Services approach to ensure extensibility, leveragability and interoperability for the transition to Green Mountain Care.

3.19.6.1 Project Monitoring and Status Reporting

Project status will be tracked and reported on an ongoing basis. Regularly scheduled status meetings between the State Project management team and the Vendor Project Manager will be held to discuss Project progress, issues, resolutions and next steps. The following standard reporting mechanisms will be used:

3. Status Reports
4. Issues Lists
5. Risk Management Updates

In addition, a Project Information Library must be developed and maintained by the Vendor and overseen by the Vendor Project Manager in a single repository used to store, organize, track, control and disseminate all information and items produced by, and delivered to the Project. The Project Information Library must include a file structure with defined access and permissions, and limited to only those Project members approved by the State project management team. It must also include an interface, such as an Internet portal, where individuals can obtain Project information, the latest documentation, and input issues or comments to the Project Team.

The State shall be the owner of all the documents available in the Project Information Library.

At a minimum, the following deliverables must be completed by the Vendor. The Vendor may propose additional deliverables as needed to achieve Project goals.

3.19.6.1.1 Deliverable 0 - Project Status Reports (Recurring Deliverable)

This deliverable must be a recurring deliverable for the entire length of the Project. The deliverable must at a minimum include weekly reporting of the following activities:

- Status of work completed against the Project Work Plan
- Objectives for the next reporting period
- Client responsibilities for the next reporting period
- Recovery plan for all work activities not tracking to the approved schedule

- Projected completion dates compared to approved baseline key dates
- Escalated risks, issues (including schedule and budget), and action items
- Disposition of logged issues and risks
- Important decisions
- Actual / projected Project Work Plan dates versus baseline Project Work Plan milestone dates
- One-page graphical summary of the Project Work Plan status of all major tasks and subtasks for each Task in a Project Plan
- Status of tasks and change requests submitted by the State

3.19.6.2 Project Initiation and Planning

At a minimum, the Vendor must complete the following deliverables. The Vendor may propose additional deliverables as needed to achieve the task goals.

3.19.6.2.1 Deliverable 1 - Project Kickoff Presentation

This deliverable is a presentation to familiarize Project team members with the Project and the Vendor's approach for completing the Project. The presentation will include at least the following topics:

- Project Overview
- Project Schedule (High Level)
- Project Objectives and Definitions
- Process for Completing the Project
- Artifacts that will be Used for the Project
- Vendor and State Resources Assigned to the Project
- Vendor and State Roles and Responsibilities
- Project Keys to Success
- Immediate Next Steps with Dates and Resources Assigned
- Questions and Answers

3.19.6.2.2 Deliverable 2 - Project Management Plan

The Vendor will provide a set of documents that, when taken together, constitute the PMP that describes how Project objectives shall be met and provides a road map for executing the Project. The approach shall be consistent with the PMI Project Management Methodologies stated in the PMBOK or equivalent.

The PMP shall address the initiation, planning, controlling, executing, and closing processes. The Vendor will be responsible for maintaining, updating and reporting on the PMP throughout the Project, and should at a minimum consist of the following:

- Project Scope
  - Purpose
  - Requirements
  - Deliverables
  - Constraints/Dependencies/Assumptions
  - Work Breakdown Structure
- Costs/Budget
  - Breakdown of costs/budget by Task and Deliverable
- Risk and Issues Analysis and Management Plan
  - Identification of Project risks and issues
  - Assessing the severity and probability of each identified risk
  - Identifying the potential impact of each identified risk and issue, developing risk and issue response plans for each identified risk and issue, and reassessing the risk level with the response
  - Providing guidance for assessing the efficacy of risk and issue mitigation actions
  - Describing work products and processes for assessing and controlling risks and issues
  - Detailing escalation mechanisms for risks and issues
  - Logging Risks and Issues

- Quality Management Plan that defines and documents Vendor's software quality assurance activities that will be implemented to ensure the MMIS conforms to all established and contracted requirements. The plan will document how the Vendor's software development and release activities and processes shall be managed, tracked and audited (from both a project management and configuration control perspective) to ensure the delivered MMIS and components thereof meet the quality standards and requirements required by the Contract developed as a result of this procurement

- Project Procurement Plan that outlines Vendor's plans for securing equipment, subcontractors and other resources

- Monitoring and Control Plan that outlines descriptions of the administrative procedures that will be used to develop, monitor, and control the Project schedule and Project monitoring activities

- Project Schedule Management Plan, including:

  - Identification criteria for determining task dependencies and critical path activities of the Project

  - Process for identifying, managing and reporting on schedule variances during the life of the Project through Corrective Action Plans

  - Process, roles and responsibilities required to making changes to the Project Schedule

  - Process for assignment of resources to the schedule and approach for managing staff and/or equipment availability to ensure completion of deliverables in accordance with Contract terms and on schedule

- Team Membership Roster that is aligned with the proposed Project Schedule that identifies the roles and responsibilities for all resources on all Project activities, including identifying the resources the Vendor and the State will provide to successfully fulfill the requirements of the Contract, including technology design, development and implementation, technology maintenance and operations, and ongoing business services

- Communication Plan that describes Vendor's roles and responsibilities regarding communications with the Vendor's immediate Project team, Subcontractors, the State and other Project stakeholders, including:

  - Communication protocols

  - Communication mode and format

- Communication content
- Communication frequency
- Audiences

- Closure Process (for Tasks and Project) in accordance with the requirements of the Contract
- Change Control Process in accordance with the requirements of this Contract

3.19.6.2.3 Deliverable 3 - Project Work Plan and Schedule

The Vendor shall deliver a Baseline Project Work Plan with an associated Baseline Project Schedule, including a Work Breakdown Structure (WBS), Gantt chart(s), and a Project calendar in Microsoft Project®. The Vendor shall document any work plan or schedule changes from the plan submitted with the Vendor's original Proposal.

The Project Work Plan and Schedule will include identification of all Phases and Tasks in the Project, their sequencing, dependencies and durations. The Project Schedule shall identify the resources to be provided by the State, together with the scheduled dates those resources will be required. It shall take into account State holidays, holidays that will be observed by the Vendor staff, periods during which the State has advised that data processing systems will be unavailable to the Vendor, and the resources that the State has committed to providing in the Contract. The Project Work Plan and Schedule, once accepted by the State, will form the Baseline Work Plan and Baseline Schedule for the Project.

As part of the Project Work Plan and Schedule, the Vendor shall prepare and submit a WBS that encompasses all activities from Project initiation and planning to Project closeout. The WBS shall define the Project's overall objectives by identifying all Project Tasks and Deliverables.

The Vendor shall maintain and update applicable portions of the Project Schedule no less than bi-weekly to reflect the current status of the Project with a comparison made to the schedule proposed in the Vendor's RFP response and Baseline Project Schedules. The Project Schedule shall be consistent with available State and Project resources. These resources will be identified by the State and communicated to the Vendor prior to Project Schedule development. The State shall have direct electronic access to the Project Schedule as well as all final and work-in-progress deliverables for immediate review and coordination of schedules and plans.

3.19.6.2.4 Deliverable 4 - Requirements Analysis, System Design and Development Strategy

Prior to the creation of detailed design or the start of any development, the Vendor shall develop and provide to the State a comprehensive Requirements Analysis, System Design and Development Strategy document, based on the requirements in the Contract and interviews

with State management and line staff. The purpose of this strategy document is to demonstrate that the Vendor has a strong understanding of the MMIS requirements and a well-defined vision of how the MMIS should be designed, developed, and implemented. This document shall include all system requirements that have been included in this Scope of Work and address how the System will be designed and developed.

The Vendor shall provide a Requirements Analysis, System Design and Development Strategy Document that includes, at a minimum a description of:

- The business processes and the functionality that the MMIS will provide
- The methodology that will be used to:
  - Analyze and validate requirements
  - Select, configure and develop the components of the System
  - Create a coherent and integrated system design
- The intended use of Commercial Off The Shelf (COTS) software in the creation of the System

3.19.6.2.5 Deliverable 5 - System Implementation Strategy

The Vendor shall provide the State with a System Implementation Strategy. The document shall include the strategy for the implementation of each Task to ensure that the Tasks together provide all functionality required of the MMIS.

The System Implementation Strategy must provide a phased approach where pre-defined success criteria for each Task of implementation provides input to key “go” / “no go” decision points for subsequent implementation Task. The System Implementation Strategy shall also identify any technical challenges (which, if any, are the sole responsibility of the Vendor to resolve) and include the deployment schedule of the Tasks.

If the Vendor proposes a phased implementation plan where portions of functionality are delivered prior to others, the Vendor must detail how each phase implements functionality in a way that meets end user business needs.

The Vendor shall provide a System Implementation Strategy document to include, at a minimum, the following components:

- Project implementation plan
- Target end-user population included in the Project
- Implementation success criteria

- Deployment schedule
- Workflow analysis and documentation
- Technology components required for the Project
- Identification of the source systems to be integrated
- Identification of technical challenges the Vendor must overcome to implement the System

3.19.6.2.6 Deliverable 6 - Master Testing Strategy

The Master Testing Strategy will ensure that the Vendor has identified the major system testing activities and associated deliverables to be performed by the Vendor. A separate and complete set of testing as outlined below is required for each phase or each release of functionality that will be put into production. Complete testing shall also be required for every MMIS interface that is built and put into production. The testing functions of the Project shall be iterative and span the entire length of the Project.

The Vendor will employ a robust test methodology based on standards set by one of the following organizations in the execution of the required system testing activities:

- Software Engineering Institute (SEI), such as the Capability Maturity Model (SEI CMM)
- International Standards Organization, such as ISO9000
- Institute of Electrical and Electronics Engineers (IEEE), such as IEEE 829 Standard for Software and System Test Documentation and related standards

The Vendor shall be responsible for populating the test system(s) with the data necessary to ensure the validity of the testing for all phases of testing. State staff shall not be required to manually enter data to pre-populate the test environment for any test phase. The Vendor shall use an automated test management tool suite to manage, assess, track, and perform the required test and deployment support activities. The Vendor shall have a software-based defect tracking system capable of providing an acceptable level of detail and reporting and, at a minimum, facilitating the following functions:

- Capture – Details about each defect will be recorded when the defect is discovered, including a description, symptoms, sequence of steps to re-create it, type, and severity
- Review and Assignment – Project management shall be able to review all open issues and assign a priority level and resources responsible for resolution

- Estimate and Resolution – Those assigned to resolve the defect shall be able to record an estimated duration and delivery date, and provide adequate explanation upon resolution
- Track Status and History – A complete history of each defect shall be maintained so that the life cycle of each defect can be tracked and reported on
- Management Reporting – The defect tracking system shall provide recurring reports to Project management throughout the Project

The Vendor shall provide the Master Testing Strategy deliverable that shall include:

- The test methodology to be employed for overall system testing
- The automated method of populating the test systems with data
- Identification of the software-based tracking system that will be employed

Additionally, the Master Testing Strategy document shall also identify and include the strategy for each of the following testing activities for each Project Implementation Phase:

- Unit and Integration Testing
- System Testing
- End-to-End Testing
- User Acceptance Testing
- Performance and Load Testing
- Security Testing

3.19.6.2.7 Deliverable 7 - Requirements Traceability Plan

The Vendor shall provide a Requirements Traceability Plan to detail the methodology for tracking the specific Functional Requirements, Non-Functional Requirements and Contract provisions of the Project. The Requirements Traceability Plan shall identify the methods, tools and technologies used to capture, catalog and manage the MMIS requirements to ensure traceability to the process workflows and detailed requirements identified in the Contract.

The Vendor shall provide a Requirements Traceability Plan document to include the approach and method of capturing and maintaining requirements traceability throughout the development and deployment process. The plan shall, at a minimum, include:

- The process the Vendor will use that identifies how the requirements traceability matrix will be developed, validated, and maintained throughout the life cycle of the Project
- The process the Vendor will use to validate functionality against requirements
- The process the Vendor will use to analyze and manage any new requirements that are approved through the State's Change Control Process
- The approach for the State team to work with the Vendor to ensure traceability of requirements to the delivered MMIS
- Identification and implementation of the tool to be used to perform requirements traceability
- Approach and methodology to track the Project requirements including:
  - Mapping the Contract requirements to a unique identifier in the tool
  - Mapping the requirements to the individual test events
  - Mapping the requirements to the individual test cases, scripts and procedures
- Approach for updating the status of the requirements based on the results of each test event
- Identification of the requirements by status (e.g., satisfied, waived)
- Identification of the reports to manage and validate the requirements, including test coverage by test event

3.19.6.3 Requirements Analysis and System Design

System design includes requirements analysis, system design, interface design, and information exchange design. Detailed and logical system design documents produced by the Vendor shall direct the MMIS development efforts. The design shall be driven by the outputs of the requirements validation. These documents provide the framework essential to ensure that the MMIS is constructed consistently, with appropriate software development methodologies and include all the functionality required by the Contract.

3.19.6.3.1 Deliverable 8 - Functional Specifications and System Design Document

In order to ensure that the Vendor fully understands the System requirements, the Vendor must lead and facilitate the process for reviewing and validating the detailed Functional and Non-Functional Requirements documentation (Response Template G.1 – Functional System Requirements and Response Template I – Non-Functional Requirements of this RFP. The Vendor shall also conduct Joint Application Development (JAD) sessions to fully explore and understand

the functional requirements for the MMIS, and to identify any gaps that the Vendor shall address in order to comply with the requirements identified in this RFP and the Contract. Based upon the outcome of the JAD sessions, the Vendor shall document in detail the design and development actions necessary to fully meet the State's requirements. The Vendor shall lead and facilitate the process for developing the Functional Specifications and System Design Document.

The Vendor shall develop and provide to the State the Functional Specifications and System Design Document to include, at a minimum, the following components:

- A comprehensive list of functional specifications to implement the functionality detailed in Response Template G.1 – Functional System Requirements with traceability between the two
- Recommendations on how to close specific gaps that require changes to the State's business processes
- A list of supported workflows mapped to business processes mapped to Functional and Non-Functional Requirements
- Identification of functions or user roles that initiate workflows, receive a workflow, and any processes that occur as a result of the workflow
- A list of identified business rules, including the definition and description of the business rules, associated business and system functions
- Reporting capabilities and reports that will be provided as part of System development
- User profiles and security role permissions
- System overview diagrams illustrating which System components provide what functionality, linking back to the functional capabilities
- Domain model
- Mock-up user interface screens for the System
- List of assumptions made during the design as well as recommended next steps and required actions that shall be confirmed by the State before the development

3.19.6.3.2 **Deliverable 9 - Data Integration and Interface Design Document**

The Vendor must deliver a Data Integration and Interface Design Document reflecting the required interfaces for the desired operations. This document must be developed based on outputs from the design sessions conducted with the Vendor and the State. The Data

Integration and Interface Design Document must include, at a minimum, the following components:

- Entity Relationship Diagrams
- Data Flow Diagrams
- Data Dictionary
- Processing controls
- Processes to manage System installation and configuration
- Data backup procedures
- Interface Definitions and Design

The Vendor must conduct a walkthrough of the final Data Integration and Interface Design Document with the State Project team to validate the contents of the Data Integration and Interface Design Document, the incorporation of all information from the design sessions, and the incorporation of all Non-Functional Requirements.

3.19.6.3.3 Deliverable 10 - System Architecture

The Vendor shall develop a System Architecture, which details the SOA model-driven framework being used across all the domains (e.g., services, trust and security, infrastructure) that enables the development of service-oriented models to facilitate the interaction between technologies. This document shall describe the set of technologies that support MMIS operations, incorporating the industry best practices and standards. It shall detail the COTS package components, design patterns, information architecture, technology infrastructure and the conceptual, logical and physical architectures for the targeted baseline MMIS.

The Vendor shall provide the System Architecture deliverable incorporating details of any COTS packages that are part of the System. This System Architecture shall define and document:

- A conceptual architecture that will produce a design to fulfill the State's functional expectations as detailed in the Functional and Non-Functional Requirements
- A logical architecture that identifies the SOA layers, Service Vendors, Service Customers, Service Broker(s), and object dependencies that comprise the proposed System. To complete the logical design model, the Vendor shall define the interfaces for each service, and include data field definitions and their validation rules

- A physical architecture that defines the various services of the System and how they shall be implemented. This shall also include details around the integration layers, potentially using Web Services, and various other integration technologies
- A detailed list of all the proposed production environment platforms, including hardware, operating system, networking and all COTS and third party systems, tools, utilities, etc.
- The details of security, privacy and consent management for the MMIS
- The technical approach to satisfy the following:
  - Network segmentation
  - Perimeter security
  - System security and data sensitivity classification
  - Intrusion management
  - Monitoring and reporting
  - Host hardening
  - Remote access
  - Encryption
  - State-wide active directory services for authentication
  - Interface security
  - Security test procedures
  - Managing network security devices
  - Security patch management
  - Secure communications over the Internet
- Detailed diagrams depicting all security-related devices and subsystems and their relationships with other systems for which they provide controls
- The High Availability and Disaster Recovery approach and plan describing how the System will enable the State to provide information to their customers in the event of a disaster

- How the architecture design features ensure that the System can scale as needed for future transaction volumes, storage requirements, and system usage expands over the expected / planned life of the System
- How the System will ensure performance based on expected data and user loading, target source systems and target platforms. Areas that shall be addressed are expected system performance during peak transaction volumes and critical key business activities
- How the System will meet capacity requirements, including:
  - A description of how system capacity and capacity requirements were calculated, including all formulas and calculations used in capacity planning for the State. This shall include:
    - Business Capacity Management
    - Service Capacity Management
    - IT Component Capacity Management
    - Capacity Management Processes
    - Capacity Management Tools Infrastructure
    - Descriptions of how capacity utilization will be monitored and capacity thresholds will be established
    - A description of corrective and escalation processes that will be used in the event any capacity thresholds are reached

3.19.6.3.4 Deliverable 11 - Technical Design Document

The Vendor must deliver a Technical Design Document (TDD), or its equivalent, reflecting the final requirements for System configuration and operation. This document must be developed based on outputs from the technical design sessions conducted with the Vendor and the State.

The TDD must include, at a minimum, the following components:

- Detailed description of system architecture
- Entity Relationship Diagrams
- Data Flow Diagrams
- Data Dictionary

- Processing controls
- Processes to manage system installation and configuration
- Data backup procedures
- Security controls
- Availability and resilience controls such as load balancing, failover capabilities, and fault tolerance

The Vendor may propose alternatives to any of these components, but they must be clearly justified and have the prior approval of the MMIS Project team.

The TDD must also include, at a minimum, the final interface definitions and design (including XML/SOAP specifications for file formats), the new System design based on reviewing existing class diagrams, sequence diagrams, updated object models that represent the internal workings and designs of the containing subsystems that will expose the services, and the component specification (details of the component that will implement the service) and service assignment to each layer defined in the system architecture.

The Vendor must conduct a walkthrough of the final TDD with the State to validate the contents of the TDD, the incorporation of all information from the design sessions, and the incorporation of all NFRs. The final TDD, once formally approved by the State, will, together with the approved Functional Specifications and Design Document (Deliverable 9), constitute the complete system definition for the MMIS. These two (2) deliverables will constitute the agreement between the State and the Vendor regarding the functionality and operation of the MMIS. The two (2) documents will be the documentation used by the Vendor during system development and use cases, and will be the basis for the development of the User Acceptance Test (UAT).

3.19.6.4 System Configuration and Development

System configuration and development efforts shall be guided by the Deliverables accepted by the State during the Requirements Analysis and System Design task. This ensures that the MMIS is built according to the documented Functional and Non-Functional Requirements.

During System Configuration and Development, the Vendor shall fully document all software components. This documentation shall support knowledge transfer to the State. Documentation shall conform to the National Information Exchange Model (NIEM) standard and follow the requirements and recommendations included in ISO/IEC standard 11179.

3.19.6.4.1 Deliverable 12 - System Implementation Plan

The Vendor shall develop a System Implementation Plan document that incorporates the final design documents for System implementation. This document shall be developed based on outputs from the planning and design sessions conducted with the Vendor and the State. The plan shall include, at a minimum, detail on the following components:

- Description of functionality for each Implementation Phase
- Phases of implementation
- Roll-out / implementation schedule for each Implementation Phase
- Points-of-contact to include individual names and contact information for each member of the Vendor and State implementation team
- Major tasks to be completed in the implementation
- Security and privacy
- Implementation support
- Hardware, software, facilities and materials for all environments
- Personnel and staffing requirements
- Outstanding issues and the mitigation plan for each
- Implementation impact and organizational change issues
- Performance monitoring
- Configuration management interface
- Risks and contingencies
- Implementation verification and validation
- Success and failure criteria definitions of the System implementation for each Implementation Phase
- Exit plan and strategy addressing portability of the System in the event the State wants to bring the System back in-house

The Vendor will provide a separate System Implementation Plan for each Implementation Phase of the Project, to include the elements outlined above and the following components:

- Project Implementation Phase roadmap

- Target end-user population included in the Implementation Phase
- Deployment schedule for the Implementation Phase
- Technology components required for the Implementation Phase
- Identification of the source systems to be integrated for the Implementation Phase

3.19.6.4.2 Deliverable 13 - Data Integration and Synchronization Plan

The State requires analysis and reporting derived from combining real-time operational data collected by the MMIS and data collected by a number of siloed source systems external to the MMIS. This external data will need to be collected and collated into an analytical repository that can be used for operational and performance reporting (static / canned and ad hoc), shared analytics, and Statewide alerts.

The Vendor shall perform the necessary data integration and synchronization work to implement the MMIS in compliance with the requirements of the Scope of Work. The Vendor shall develop a detailed plan to validate all integration and synchronization routines, as well as the accuracy and integrity of all data integrated from the source systems or otherwise generated.

The Vendor shall design, develop, and implement the technology infrastructure required to enable the data integration described in the Functional and Non-Functional Requirements of this RFP as well as integration with operational data resident in existing State systems. Operational data integration shall focus on combining select data elements from a variety of existing data sources to present a dynamic / temporary view of authorized and relevant Member information, as well as the State's relationship with that individual across all departments and programs within the scope of the Project.

The Vendor shall provide an analytical data integration infrastructure that includes consistent data across the enterprise to meet the analytics needs. This data must be available in a form suitable for the required analytics and reporting functionality defined in this RFP and available to authorized users.

The Vendor shall provide a Data Integration and Synchronization Plan to include, at a minimum, all the elements of operational and analytical data integration described above.

3.19.6.4.3 Deliverable 14 - System Maintenance and Support Plan

The Vendor shall provide a written plan for the Maintenance and Operations Support of the MMIS in the production environment.

The following documentation, at a minimum, shall be prepared by the Vendor and included in the System Maintenance and Support Plan provided to the State:

- System support structure and organization, including estimates of manpower requirements to support operation and maintenance of the System
- System Installation and Administration Manual
- The location and maintenance approach for all completed code associated with the MMIS
- Operating Procedures Manual: Includes Diagnostic procedures, backup and restore procedures, and disaster recover procedures
- Maintenance Manual: Information to aid in analyzing and debugging the software, apart from information already available in other delivered documentation
- Maintenance and repair policies and procedures
- Updated system architecture diagrams and inventory (systems, servers, etc.) that clearly identify what is in the pilot and in production use
- MMIS database schema
- MMIS Data Dictionary
- MMIS "Run Book"

3.19.6.5 Testing

The MMIS must undergo a series of System and UATs prior to deployment. This includes emphasis on testing new or changed functionality, as well as regression testing of already accepted functionality to ensure that changes to software have not adversely affected existing code. Each phase of testing requires the development of a thorough Test Plan, including test cases, scripts, data sheets, and expected results. The tests that are developed must be repeatable and must be directly traceable to the requirements.

System testing and UAT must be driven by Functional and Non-Functional Requirements and design sessions, and must adhere to detailed test plans and test scripts. The State and Vendor have significant roles in the testing process. The Vendor must thoroughly test the software itself before the State UAT team begins their work. The Vendor responsibilities prior to State UAT include System / integration testing, volume and stress testing, performance testing, and load balancing testing. When the Vendor test results are validated by the State, UAT can commence. Upon the completion of the UAT, overall readiness will be assessed and a "go" / "no go" decision for System deployment will be made by the State.

3.19.6.5.1 Deliverable 15 - Test Plan

The Vendor will be responsible for the development of a Test Plan, which includes the following testing events:

- Unit and Integration Testing – The Vendor shall perform Unit and Integration testing as necessary during the configuration/development process. The State will require the presentation of Unit and Integration test plans and results during scheduled development review meetings

- System Testing – The system testing is aimed at proving that the System meets the stated requirements and objectives by validating the total System in a real world scenario. This testing shall be performed by the Vendor but may be supported by a limited number of State power-users (not end-users) at the sole discretion and to the limit deemed appropriate by the State Project Manager. System testing will be combined into a single test phase to provide streamlined testing without compromising the testing objectives.

  - Entry Criteria – The feature set, although largely defined and static, may still not be completely finalized. All features that have not yet been implemented are prioritized in case postponement of certain features is desired by the State. The software has been unit tested, and there is a high level of confidence the completed MMIS software is ready.

  - System Test Execution – The System Test shall utilize "real" data, and shall be performed by the Vendor or a third party. The System Test shall demonstrate the critical business functions of the System and the overall effectiveness of the user-facing aspects. At a minimum, the Vendor shall incorporate the following activities during System Testing, to be defined and approved by the State:

    - Demonstrate Critical Business Function Scenarios (as defined by and approved by the State) – data and processes must be fully integrated across functional areas and that integration fully demonstrated

    - Transaction Testing

    - Error Message Testing

    - Documentation Testing

    - Help Systems Testing

    - Demonstrate the Complete Sequence of Functional Business Tasks

    - End-to-end business process testing

- Report Generation and Printing
- Interface Testing (all interfaces included in the module/system)
- Usability/Interface Testing
- Reliability Testing
- Performance Testing (including stress and load testing)
- Security Testing
- System Recovery and Restoration Testing
- Regression Testing
- Integration Testing
- Integrity Testing

❑ Exit Criteria – The results of the System Test are to be presented to the State for approval before the development system status can be promoted to UAT stage for end user testing. This presentation shall take the form of a live demonstration of System functionality as outlined below. The State shall define, no less than 20 business days before the start of System Test phase, the criteria necessary for State approval of test results, including requirements for presentation of the results to the State and timeframes for State review

■ User Acceptance Testing – The purpose of UAT is to confirm that the System has been developed according to the State's Functional and Non-Functional Requirements and that it is ready for enterprise deployment and operational use. During UAT, selected State end-users will compare the System's functionality, features, and performance to the Requirements and the State documented UAT exit criteria.

❑ Entry Criteria – Prior to moving from System Testing to UAT, the System's feature set shall be fully defined and static. The code shall be complete and frozen. The final release version shall have been built from source control. This final version shall have passed a formal Vendor QA acceptance test.

❑ Pre Test – The Vendor shall perform the following activities prior to User Acceptance and Reliability Testing (UAT):

- Build the UAT System release
- Develop and document the software build instructions for UAT

- Install and configure the UAT release system components and database(s) on the system testing environment
- Develop and provide the required UAT documentation (e.g., end user guides, systems administration manuals, user help files) and provide to the State for approval for use during UAT activities
- Complete all Engineering Change Requests (ECRs)
- Load database(s) with complete and validated production-ready dataset
- Develop comprehensive UAT scripts that test all Requirements as specified in this RFP in a logical and business process-oriented manner

❑ Conduct UAT – There are a number of activities that the Vendor and the State must perform for the completion of the UAT. At a minimum, the following activities shall be performed:

- State and Vendor to identify the required State and Vendor resources to support UAT activities
- Vendor to provide Vendor resources to support UAT activities
- Vendor to develop the defect resolution management plan
- State to review and accept the defect management plan
- Vendor to develop the overall UAT Test Plan and schedule
- State to review and accept overall UAT Test Plan and Schedule
- Vendor to develop required UAT Test Cases - Each requirement identified in the RFP shall be tested by at least two (2) Test Cases. One (1) Test Case may provide for the testing of multiple requirements
- State to review and accept UAT Test Cases
- Vendor to compile all relevant data needed to permit State to validate that the System meets all Functional and Non-Functional Requirements. The Vendor will collect the following supporting materials:
  - » The Project Statement of Work
  - » Systems Requirements Documents
  - » Software Requirements Document

» Requirements Traceability Matrix

» Systems Configuration Management Data

» End-user Documentation (user manuals, systems administration procedures, and training documents)

» State-approved UAT Test Plan

- Vendor to compile and evaluate the UAT test results
- State to approve the UAT results and any Corrective Action Plans
- State to accept the overall System and its readiness for production deployment
- Vendor to respond to all problem / error reports within three (3) calendar days. Any Severity 1 (causing the System to fail to perform a basic business function) problem shall be responded to within four (4) hours. The acceptability of remedial fixes will depend on the nature of the problem, but shall be solely at the State's discretion. When UAT tests are rerun, the reruns shall be treated as any other UAT test activity and documented accordingly.

» The Vendor to warrant that the Software, as amended for rerun, is feature complete. To ensure that modifications to the software can be considered by State as a low risk to the underlying stability of the System, the software shall have been rigorously tested by the Vendor's QA and the original software developer's QA.

» Exit Criteria – The requirements for release from UAT are zero Severity 1 and zero Severity 2. The default State requirement for Severity 3 is zero. However, if actual Severity 3 defects are greater than zero, the Release Committee will review the defects and make a recommendation to the State whether to release to production or not. The State and Vendor Project Managers will meet and mutually agree on an acceptable level of Severity 4-5 defects in order to move forward. Defect levels of severity are as defined above.

» All known problems are to be reviewed by the Release Committee. No outstanding problems should affect overall customer expectations for the System. Supporting materials such as release notes, user manuals and training manuals shall be in final form and shall also be verified by the Vendor's QA or other appropriate reviewers. Customer support (if applicable) shall be fully prepared to support the product at this point.

» The Vendor shall present in person the results of the completed UAT process to the State. The Vendor shall also prepare a report detailing any remaining defects of all severities and the expected impacts of each, and deliver the Report at the same time as the presentation. The State will review the results and approve or reject the completion of the UAT phase.

- Performance and Load Testing – The Vendor shall perform Performance Testing. Performance Testing shall include both stress and load testing to verify System performance in accordance with the SLRs and Performance in Response Template I - Non-functional Requirements.

- System Regression Testing – The Vendor shall perform System Regression Testing throughout the testing process to verify System integrity after functional improvements or fixes have been made as a result of System Integration and UAT activities. Regression testing shall be designed to confirm that fixes have not created any new problems and that the results are as planned. The results will also define the System baseline configuration to be released to the State. The Vendor team shall document all tests performed. It shall be the responsibility of the Vendor to ensure all automated test scripts have been assessed to ensure their proper function.

The Vendor shall provide a Test Plan that includes the elements outlined above and a detailed schedule for each of the activities to be completed within the test phase, including the individuals (name and role) responsible for the completion and or approval of each activity. Activities in the Test Plan shall include, at a minimum, the following components:

- Definition of the Test Tasks and Objectives
- Entrance Criteria for the Test Tasks
- Exit Criteria for the Test Tasks
- Key milestones (i.e., relationship in terms of timeframes days / weeks/ months, to predecessors and successor tasks) associated with each Testing Task, including:
  - ❑ Test Case Approval
  - ❑ Test Environment Readiness
  - ❑ Test Start and End dates
  - ❑ Code Baseline Configuration Established
  - ❑ Code Freeze Date(s)
  - ❑ Required Approval Dates for Test Cases, Entrance and Exit Criteria, etc.

- ❑ Regression Testing start and end dates
- ❑ Test Results Review Meeting Completion
- ❑ Code Promotion "Go" / "No Go" Decision

3.19.6.5.2 Deliverable 16 - Test Scenarios, Test Cases and Test Scripts

The Vendor shall develop comprehensive Test Scenarios, Test Cases and Test Scripts that test each requirement in a logical and business process-oriented manner. The Test Scenarios, Test Cases and Test Scripts will cover all test events defined above. The Test Scenarios, Test Cases and Test Scripts will also be supported by Vendor-developed data sheets that reference the test cases to the Requirements to ensure comprehensive coverage of each test event specified in this RFP. All developed artifacts will be reviewed and approved by the State.

3.19.6.5.3 Deliverable 17 - Documented System Test Results

The Vendor shall provide comprehensive Documented System Test Results for each test event identified in this RFP for State review and approval.

The Vendor shall provide Documented System Test Results that include all of the test activities identified above, with the following components for each test event:

- Test Coverage Matrix for each Test Task identified (excluding Unit and Integration Testing)
- Completed Systems Requirements vs. Functionality Tested Matrix for each phase and for the final System delivery
- Defect Reports
- Monthly Test Issues and Mitigation Reports
- Test Phase Final Results Report and Corrective Action Plans

3.19.6.6 Training

The Vendor will provide all State and Provider staff with the skills and knowledge that will enable them to deliver and monitor necessary services using the System in the most productive manner. The MMIS training must, at a minimum, provide the following:

- Build adoption of person-centered service delivery to support the objectives of Vermont's Agency of One vision
- Increase collaboration and coordination among State programs through use of the MMIS

- Enable authorized System users to be self-sufficient in the use and extension of the System through the various configuration and parameter change capabilities
- Provide the State the ability to efficiently and effectively assume training responsibilities subsequent to implementation

The Vendor shall engage professional training staff specializing in business systems training to work with State staff to develop and implement a Training Plan for the Project, deliver initial training, develop on-going training curricula and material, develop reinforcement training material, and evaluate the effectiveness of the MMIS training. A Training Team consisting of training specialist, Vendor and State staff shall be responsible for the training program and shall participate in various Tasks of the Project to gain an understanding of System design and functionality. The Training Team shall have direct access to the Project test systems in order to map workflows and copy system screens, outputs and other materials needed to produce the documentation necessary for staff training. The professional training staff engaged by the Vendor shall provide all user training specified in this Contract.

Although State staff will participate in decisions on Training Plans and materials, the Vendor is solely responsible for creating those plans and materials, implementing the Training Plan and delivering the training for the duration of the Contract.

The Vendor will:

- Provide effective training on the required knowledge, skills, and abilities necessary to use the MMIS to deliver services using a person-centered model
- Provide timely training, which ensures transition from training to actual operations and application to staff work
- Provide necessary reinforcement training following initial training
- Ensure that there is easy access to training for trainees, including ongoing training for Providers
- Be responsible for the development of user training curricula, schedules, training materials and training evaluation materials in accordance with the accepted Training Plan
- Be responsible for assisting the State with the setup and maintenance of an online training environment that allows State and Provider trainees to access the System
- Be responsible for conducting face-to-face, hands-on, user training in logical groupings at locations determined by the State, and for managing all training planning and logistics in coordination with the State

- Develop on-line instruction material for Members regarding access to their service information and features in MMIS.
- Provide a learning metric for this program to access a user's understanding and ability to use the information they have acquired from the Vendor provided training

The user training, in addition to focusing on the navigation and functional use, shall also focus on how the System is integrated into the day-to-day work of all end users, including new business processes and/or workflows related to the State's new Model of Practice. To the fullest extent possible, the training classes shall consist of trainees with similar job duties and materials and approach should reflect a user-specific focus, including the use of user-specific case scenarios. User engagement and behavior change is critical to the achievement of the State's objectives for the MMIS implementation. As such, the Vendor will be responsible for organizing training in an interesting, non-technical manner to keep the trainees' attention. Innovative training aides, case studies, scenarios, humor, gamification, and other learning tools that will engage the users and support information retention are encouraged.

3.19.6.6.1 Deliverable 18 - Training Plan

The purpose of the MMIS Training Plan is to identify the activities and define the curricula that the State needs to support its long-range plans to implement person-centered service delivery supported by the MMIS and specific transactional training requirements. The Vendor shall include in the Training Plan delivery of Provider training as well as State staff training.

The Vendor shall provide a Training Plan that meets the requirements described above and, at a minimum, the following components:

- Overview stating the purpose and scope of the Training Plan that meets the requirements of this RFP
- Training Curricula
  - Detailed description of the training model
  - Flow diagrams and detail for the training curriculum for each functional area and integration into the end-to-end business process
  - Specific training curricula targeted and delivered to the different users in a manner that meets their specific needs including, but not limited to, MMIS user training focusing on hands-on MMIS usage to enable users to accomplish their day-to-day activities including performance management through business analytics and reporting
- Training Materials Development Plans

- Role of the Training Team
- Documentation style standards for the development of training material (e.g., document format, references, acronyms, font)
- Plan for review of training material
- Approach to prototyping and testing training materials with training customers
- Approach to modifying or adjusting training materials based on the results of the evaluation of training
- Training equipment plans: Vendor shall provide all training facilities and equipment

- Training Methodology and Delivery Plans:
  - Identification of the training mix including, but not limited to: web-based learning, in-person learning, phone conferences, learning-labs, and informal learning. Because of the constraints related to scheduling staff out of the office for multiple training sessions, Vendor shall develop a training mix that leverages use of on-line training tools and self-guided learning material that is supported by in-person training
  - Identification of plan to motivate and engage MMIS users to learn about and use the System and complete the training
  - The logistical plan for preparing and delivering the training solution
  - Training Schedule: Schedule and timeline of training development, delivery, and evaluation
  - Ongoing and targeted training specific to Provider groups

3.19.6.6.2 Deliverable 19 - Training Manuals, Guides and Materials

The Vendor shall develop and maintain current training materials in such a way as to allow for training to continue beyond initial deployment. This includes the ability to modularize the material. All training material shall have a consistent look and feel and shall be provided in a soft copy format so that the State may easily make modifications to the materials. All training materials shall be maintained to reflect the latest version of the MMIS and the changes resulting from evaluations and use during acceptance, pilot testing, and implementation. All training material shall be maintained in a centralized on-line repository.

The Vendor shall be responsible for developing and providing training materials and for training State and Provider staff on System operations. The Vendor shall employ professional training

staff (not technical staff) to conduct training sessions and to prepare training and user materials. The State shall have approval over Vendor-provided staffing used for training and over the format/content of the training to be given. The State and Vendor staff shall work together to develop the format/content for the training and user materials that the Vendor shall produce. These materials shall be provided to the State in both hard and soft copy. The State must accept these materials before they are distributed to State staff and Providers for use.

Training Manuals, Guides, and Materials shall include, at a minimum:

- Instructor/Trainer Guides, which will provide the ability for State staff to perform the training on a continuing basis
- Trainee Packages, which will provide the trainees exercises and usable examples with which to practice the lessons provided during formal training
- System User Manual, which will provide MMIS information. It should be as non-technical as possible and emphasize program collaboration, and related business functions in the explanation of MMIS features, functions, modules and tools and the detailed procedures for using the MMIS. The System User Manual shall be designed for ease of use so that any user, regardless of his or her function, can readily locate, identify, understand and use the information. The manual shall include a description of the problems and issues that may arise in using the MMIS and the procedures for resolution. The manual shall include copies of all screens with instruction on the use and function of each, including the definition of all data elements. System User Manual shall include a catalog of all reports, forms, letters, and other system-generated documents (generated either automatically by the System or by the user). This catalog shall include, at a minimum, a copy of each report, form, letter, or document together with a description of its contents and step-by-step instruction on how to produce it.
- Desk Aids shall provide, at a minimum, quick access to solutions and information that users most frequently need
- User Tip Notifications, which shall be designed as short email or System messages that can be sent to recent trainees with reminders about short-cuts, features, and other relevant information to promote end-user adoption and use of the MMIS

3.19.6.6.3 **Deliverable 20 - Documented Evidence of Successful End-User Training**

The Vendor shall provide Documented Evidence of Successful End-User Training at the end of each phase of training. Evidence shall include, at a minimum, the following components:

- Tracking of trainee attendance and completion of training courses and modules
- Actions addressing any deficiencies in the proficiency of the current cohort of trainees based on the results of the evaluation of training effectiveness
- An action plan to adjust or modify future training based on the evaluation outcomes

3.19.6.6.4 Deliverable 21 – Operations Quality Plan

The Vendor shall provide a Quality Plan that establishes and maintains uniform excellence in the delivery of services and to improve the quality of services and the competence of all staff responsible for the delivery of services. The Quality Plan identifies performance indicators that measure and evaluate service outcomes to help ensure compliance with quality standards and contractual obligations. The Quality Plan should address at least the following areas:

- Scope and overall objectives of the quality management and the quality plan
- Responsibilities, including individual roles and coordination between roles
- Quality monitoring and assessment
- Call quality management including supervisor/manager quality control review, quality assurance call audits, quality monitoring criteria, call scoring, coaching and feedback, calibration sessions, customer satisfaction survey, complaints (if necessary)
- Mail room quality management including monthly mail room quality assurance, mail room reporting, and document control (if necessary)
- Staff evaluations
- Quality management reporting including internal quality reports and customer satisfaction considerations
- Continuous improvement identification and opportunities management
- Resource and policy development process
- Staff retention including retention monitoring and strategies
- Corrective and preventive action including informal and formal remediation
- Subcontractor monitoring (if necessary)

3.19.6.7 Deployment Strategy

The Vendor shall produce a detailed and thorough plan for deployment of the planned functionality for each phase.

3.19.6.7.1 Deliverable 22 - Deployment Plan

The Vendor shall provide a detailed Deployment Plan that documents all the activities that need to be accomplished to successfully migrate the MMIS from the testing environment to the production environment. The Deployment Plan shall provide a detailed schedule of activities with key "go" / "no go" decision points identified throughout the deployment process. In addition, the plan shall detail a back-out and recovery process to be triggered in the event the turnover to production fails.

3.19.6.7.2 Deliverable 23 - CMS Certification Planning

The Vendor must initiate planning activities associated with Federal certification of the MMIS. Planning activities should ensure the System meets all CMS requirements and performance standards to qualify for the highest eligible Federal Financial Participation (FFP) rate retroactive to the first day of operation. While certification application activities will occur post-implementation, the Vendor should start preparation at the beginning of the project and continue through each step of the design, development, testing and implementation of the MMIS. Upon full implementation of the System, the Vendor must ensure that the MMIS obtains CMS Certification. At the time of full MMIS Certification, the Vendor will:

- Develop a CMS Certification Checklist
- Complete all tasks required to attain certification
- Support the State in all discussions with CMS regarding certification
- Develop and execute on required and suggested remediation efforts to achieve certification
- Assist the State in preparing certification documents and reports
- Review and report on the progress and compliance with CMS Certification

3.19.6.7.3 Deliverable 24 - System Incident and Defect Resolution Report

The Vendor shall document all incidents and defects that occur during System Deployment that are part of the System scope and communicate with the State Project Manager within a reasonable, agreed upon time frame, on a regular basis. The System Incident Report must contain the priority of the incident, a description of the incident, incident resolution status, and the proposed course of action for remedying all open incidents.

All changes and fixes will be implemented based on a mutually agreed upon schedule. All changes will go through all phases of testing by the Vendor and the State Project team. The Vendor shall document the test results and provide to the State for approval before a decision is

made to put the new release into production. The Vendor shall update all required System documentation as appropriate and provide to the State at the conclusion of any System changes.

3.19.6.7.4 Deliverable 25 - Completed Detailed Functional and Technical Specifications Traceability Matrix

After completion of each Implementation Phase and upon final System delivery, the Vendor shall assemble, update, and provide an updated Completed Detailed Functional and Technical Specifications Traceability Matrix document for the MMIS Project. The document components shall include, at a minimum, the following components:

- Updated Functional Requirements with disposition in the Functional Specifications and Design Document (refer to Deliverable 9)
- Updated Non-Functional Specifications with disposition in the Technical Design Document (refer to Deliverable 12)

3.19.6.7.5 Deliverable 26 - System Source Code and Documentation

At the completion of the Project, the Vendor shall conduct a review with the State and identify any documentation that must be updated as a result of changes during the two-year warranty period. The two-year warranty period starts after the full scope of the Project is released into production (i.e., deployment of all phases) and is deemed successful by the State. The Vendor will be required to update the documentation and provide it to the State for review and final acceptance.

The following shall be updated and provided to the State MMIS Project Manager at the completion of the Project:

- Functional Specifications and Design Documentation
- System Architecture
- Technical Design Documentation
- Data Management and Synchronization Plan
- Test Cases and Test Scripts
- Training Manuals, End-User Guides, and Materials
- Final versions of the System software files

The Vendor shall also transfer all finalized required documentation to the State. The format and the medium of transfer will be at the discretion of the State.

3.19.6.7.6 Deliverable 27 - Performance SLAs

The Vendor shall provide ongoing compliance monitoring and reporting for the SLAs summarized in the Section entitled System and Medicaid Operations Services Performance Management above and included in detail in Response Template I - Non-Functional Requirements.

3.19.6.8 Phase Closeout

The purpose of the Project Phase Closeout Task is to identify the conclusion of a Project Implementation Phase and gather the required approver signatures. This document will signify that all required deliverables for the Project Implementation Phase being closed have been completed and approved with the date of approval for each deliverable indicated. The document shall also list the status of each of the exit criteria for the Project Implementation Phase.

3.19.6.8.1 Deliverable 28 - Phase Closeout

The Vendor shall provide documentation to support Phase Implementation Closeout to include, at a minimum, the elements described above and the following components:

- State validation that all deliverables for the Implementation Phase have been provided, accepted, and placed in the Project repository
- State validation that all exit criteria for the Implementation Phase have been met
- State validation that all appropriate transition tasks have been completed

3.19.6.9 System M&O

At a minimum, the Vendor must complete the following services. The Vendor may propose additional deliverables as needed to achieve the task goals of System M&O:

- **System Incident Resolution:** M&O of the System includes software faults that are not a part of the scope of the original development effort. All incidents that occur as part of ongoing operations must be addressed and resolved within a reasonable timeframe as per the SLAs described in this RFP.
- **Adaptive Maintenance:** All changes and fixes will be implemented based on a mutually agreed upon schedule. All changes will go through all phases of testing by the Vendor and the State. The test results must be documented and provided to the State for approval before a decision is made to put the new release into Production. All relevant System documentation will be updated and provided to the State at the conclusion of any System changes.

- **System Enhancements:** If the State determines that System enhancements are required, it will submit a request for those modifications to the Vendor. The Vendor will analyze the changes and provide a cost estimate for performing those changes to the MMIS. These cost estimates will be negotiated based on rates proposed and agreed to in Response Template O - Cost Workbook. The State can then decide whether it wishes to move forward with the requested enhancements, which will be incorporated as a change order to the Contract.

3.19.6.9.1 Deliverable 29 - System Incident Reports – M&O

All incidents that occur during the base and optional extension M&O periods must be documented and communicated with the State within a reasonable, agreed upon timeframe, on a regular basis. The System Incident Reports must contain the severity of the incident, a description of the incident, incident resolution status, and the proposed course of action for remedying all open incidents.

3.19.6.9.2 Deliverable 30 - Adaptive Maintenance Report

All adaptive maintenance requests that occur during the M&O period must be documented and communicated with the State within a reasonable, agreed upon timeframe, on a regular basis. The Adaptive Maintenance Report must contain the description of the maintenance request, resolution status, and the proposed course of action for remedying all open maintenance requests.

3.19.6.9.3 Deliverable 31 - System Enhancement Report(s)

All system enhancement requests (changes requiring 200 or more hours of effort) that occur during the M&O period must be documented and communicated with the State within a reasonable, agreed upon timeframe, on a regular basis. The System Enhancement Report must contain the description of the enhancement request, progress, and the test results and outcome of each request.

3.19.6.9.4 Deliverable 32 - Service Desk Support Plan

The Vendor is responsible for developing a Service Desk Support Plan that includes the plan to provide a Tier 2 Help Desk and describes how support will be provided and how escalated incidents are resolved. The Help Desk shall use ITIL v3 compliant Incident and Problem Management processes. The plan must include a proposed organizational structure, service level commitments related to the resolution of logged incidents (based on issue priority or severity), and metric reporting for monitoring the System and Help Desk performance. The Help Desk shall use an ITIL v3 compliant COTS IT Service Desk solution and shall electronically interface with the Vendor's defect and quality management tools.

3.19.6.10 Operational Deliverables

At a minimum, the Vendor must complete the following services. The Vendor may propose additional deliverables as needed to achieve the Operations Services.

3.19.6.10.1 Deliverable 33 - Monitoring the Implemented Solution

The Vendor is responsible for monitoring the implemented Solution for quality control and verification that all activities are functioning properly.

3.19.6.10.2 Deliverable 34 - Weekly Reporting of any Problems Identified

The Vendor is responsible for weekly reporting of any problem identified, the proposed repair or remedy, and impact of the repair or remedy and the scheduled implementation date.

3.19.6.10.3 Deliverable 35 - Monthly Status Reports

The Vendor shall be required to provide a Monthly Status Report, which shall address overall Service and System status against the current and Baseline Project Schedule and Plans and the defined Service Level Requirements. It shall cover progress against plans for the previous review period and identify work planned for the next work period, or longer if circumstances dictate. The Monthly Status Report shall address issues and concerns, action items and other pertinent information needed by the Vendor or requested by the State as necessary and applicable to the Phase of the Project and the Operational Services being provided. The presentation of the Status Reports shall be both written and oral. Status report meetings shall include both State and Vendor management staff.

The Vendor shall provide Monthly Status Reports to include, at a minimum, the following elements:

- Major tasks accomplished
- Approved scope changes
- Risks / issues identified and a detailed report of the planned or completed mitigation thereof
- Critical path items expected to occur during the next month

3.19.6.10.4 Deliverable 36 - CMS Certification Documentation

The Vendor is responsible for preparing all documentation and operational examples to demonstrate criteria are met and System and Medicaid Operations Services operations address all business functions and performance standards and business model expectations for certification.

3.19.6.10.5 Deliverable 37: CMS Certification Electronic Document Storage

The Vendor is responsible for establishing a shared electronic document storage where certification materials and supporting documentation can be uploaded, organized and accessed by CMS during onsite review.

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4.0 Proposal Evaluation

The State will use a formal evaluation process to select the successful Vendor(s). The State will consider capabilities or advantages that are clearly described in the Proposal, which may be confirmed by key personnel interviews, oral presentations, site visits, demonstrations, and references contacted by the State. The State reserves the right to contact individuals, entities, or organizations that have had dealings with the Vendor or proposed staff, whether or not identified in the Proposal.

The State will more favorably evaluate proposals that offer no or few exceptions, reservations, or limitations to the terms and conditions of the RFP, including the State's General Provisions.

4.1 Evaluation Criteria

The State wishes to receive a broad set of innovative responses that will position it for a rapidly changing environment but still provide a low risk approach to more rapid development and deployment of an MMIS than has been the norm in the industry. Vendors are encouraged to provide the solution that will best help achieve the needs and goals and requirements as stated in the RFP, including the extensibility and adaptability necessary to support the State's envisioned Green Mountain Care 2017.

The State has a preference to leverage current investments in technology, however, the State will entertain proposals from Vendors proposing innovative solutions, so long as there is a compelling justification for the procurement of the solution, the solution meets all the requirements provided in this RFP, and provides the State with best value option including costs for development and deployment as well as total cost of ownership.

The State will evaluate proposals in the context of the response type it was submitted for, and in the context of the best value overall approach for entirety of the systems and services requested. The State will, at its discretion, select one or more Vendors that provide the overall best value for these components.

The State will evaluate proposals based on the following best value evaluation criteria:

- Vendor Experience, including:
  - Relevant Vendor Experience
  - Customer References
- Project Staff and Project Organization, including:
  - Project Organization

- Key Project Personnel Experience

- Business Solution, including:
  - Functional Operation
  - Generalized System Behavior / Technology
  - Implementation Approach
  - Ongoing Operations Approach
  - Services Approach
- Cost
  - Initial Implementation
  - Ongoing Operations
- Risk and Complexity
  - Contract management
  - Vendor Management
  - Operations and Organization

4.2 Initial Compliance Screening

The State will perform an initial screening of all proposals received. Unsigned proposals and proposals that do not include all required forms and sections are subject to rejection without further evaluation. The State reserves the right to waive minor informalities in a proposal and award contracts that are in the best interest of the State of Vermont.

Initial screening will check for compliance with various content requirements and minimum qualification requirements defined in the RFP. The State also reserves the right to request clarification from Vendors who fail to meet any initial compliance requirements prior to rejecting a proposal for material deviation from requirements or non-responsiveness.

4.3 Minimum Mandatory Qualifications

If the Vendor (Prime and/or Subcontractor) does not maintain these credentials or cannot demonstrate compliance with all of these requirements to the State, the Vendor's Proposal may be rejected.

For MMIS and Medicaid Operations Services:

- The Vendor must have at least five (5) years' experience with projects of similar size and scope to the State's that include design, configuration, implementation of a MMIS in compliance with all Federal and State regulations.
- The Vendor (Prime only) must submit at least three (3) references using Template C to verify that Vendor has experience in the design, development and implementation of at least three (3) solutions similar in size, complexity and scope to this component of the procurement in the past five (5) years.
- The MMIS proposed by the Vendor must have been previously implemented successfully in a State environment.
- The Vendor must have at least five (5) years' experience in operation of a MMIS, including Fiscal Agent services, in similar size and scope to the State's in compliance with all Federal and State regulations.

For Contact Center systems and services:

- The Vendor must have at least five (5) years' experience with projects of similar size and scope to the State's that include design, configuration, implementation of a Contact Center in compliance with all Federal and State regulations.
- The Vendor (Prime only) must submit at least three (3) references using Template C to verify that Vendor has experience in the design, development and implementation of at least three (3) solutions similar in size, complexity and scope to this component of the procurement in the past five (5) years.
- The Contact Center systems proposed by the Vendor must have been previously implemented successfully in a State or insurer environment.
- The Vendor must have at least five (5) years' experience in operation of a Contact Center in similar size and scope to the State's in compliance with all Federal and State regulations.

The Vendor must demonstrate compliance with the above mandatory requirements in Response Template A – Cover Letter and Executive Summary.

4.4 Competitive Field Determinations

The State may determine that certain proposals are within the field of competition for admission to discussions. The field of competition consists of the proposals that receive the highest or most satisfactory evaluations. The State may, in the interest of administrative efficiency, place reasonable limits on the number of proposals admitted to the field of competition.

Proposals that do not receive at least a defined number of the evaluation points for each of the evaluation criteria, may, at the sole discretion of the State, be eliminated from further consideration.

4.5 Oral Presentations and Site Visits

The State may, at its sole discretion, request oral presentations, site visits, and/or demonstrations from one or more Vendors admitted to the field of competition. The Key Personnel as identified in the Vendor's Proposal must be active participants in the oral presentations – the State is not interested in corporate or sales personnel being the primary participants in oral presentations. This event, if held, will focus on an understanding of the capabilities of the Vendor and importantly identified key personnel's ability to perform consistent with the Vendor's Proposal in meeting the State's requirements. The State will notify selected Vendors of the time and location for these activities, and may supply agendas or topics for discussion. The State reserves the right to ask additional questions during oral presentations, site visits, and/or demonstrations to clarify the scope and content of the written Proposal.

The Vendor's oral presentation, site visit, and/or demonstration must substantially represent material included in the written Proposal, and should not introduce new concepts or offers unless specifically requested by the State.

4.6 Best and Final Offers

The State may, but is not required to, permit Vendors to prepare one or more revised offers. For this reason, Vendors are encouraged to treat their original Proposals, and any revised offers requested by the State, as best and final offers.

4.7 Discussions with Vendors

The State may, but is not required to, conduct discussions with all, some, or none of the Vendors admitted to the field of competition for the purpose of obtaining the best value for the State. It may conduct discussions for the purpose of:

- Obtaining clarification of Proposal ambiguities;
- Requesting modifications to a Proposal; and/or
- Obtaining a best and final offer.

The State may make an award prior to the completion of discussions with all Vendors admitted to the field of competition if the State determines that the award represents best value to the State of Vermont.

4.8 Award Determination

All purchases, leases, or contracts, which are based on competitive proposals, will be awarded according to the provisions in the Request for Proposal. The Procurement Team will evaluate the proposals based on responsiveness to RFP key points and forward the completed scoring tools as well as copies of the proposals to the Deputy Commissioner for final review and determination of any award.

The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

4.9 Notification of Award

DVHA will notify all bidders in writing of an award determination. DVHA will notify all bidders when the contract(s) resulting from this RFP are signed by posting to the Electronic Bulletin Board (http://www.vermontbidsystem.com).

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5.0 Glossary of Acronyms and Terms

A

ACCESS: State of Vermont's current Integrated Eligibility System

Ad Hoc Query: Queries created by users to obtain information for a specific need as it arises

Accountable Care Organization (ACO): Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients.

Accounts Receivable (A/R): A financial ledger

Affordable Care Act (ACA): On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act. On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 was signed into law. The two laws are collectively referred to as the Affordable Care Act (ACA). The Affordable Care Act expands Medicaid eligibility: effective on January 1, 2014, Medicaid will be available for the first time to individuals without minor children earning less than one hundred thirty-three percent (133%) of the Federal poverty level (FPL).

Aged Blind and Disabled (ABD): A Medicaid eligibility category

Agency of Education (AOE): An Agency within the State of Vermont

Agency of Human Services (AHS; "the Agency"): Vermont's agency that administered the majority of the State's health and human services programs. AHS is the State's Single Medicaid Agency

Audit: Audit utilizes historical claims data to determine whether the service being billed has any limitations

ARIS: ARIS Solutions is a 501(C)3 non-profit corporation that provides fiscal agent services within Vermont

Automated Voice Response System (AVRS): See Interactive Voice Response System

B

Blueprint for Health ("Blueprint"): The Blueprint for Health (Blueprint) is Vermont's state-led initiative charged with guiding a process that results in sustainable health care delivery reform. Originally codified in Vermont statute in 2006, then modified further in 2007, 2008, and finally in 2010 with Vermont Act 128 amending 18 V.S.A. Chapter 13 which defines Blueprint as a "program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management."

Business Intelligence (BI): The process or capability of gathering information in the field of business; the process of turning data into information and then into knowledge

Business Process Analysis: Methodology used for developing a system's Functional Requirements by establishing an understanding of the as-is environment and identifying the to-be operational business and service delivery processes of the future system

C

Catamount Health: A health insurance plan, offered in cooperation with the state of Vermont, by Blue Cross Blue Shield of Vermont and MVP, which ended on 3/31/14 due to implementation of the ACA

Contact Center: A portion of this RFP that manages inbound and outbound calls, outgoing mail, and specific processes for members and providers

Cash Management Improvement Act: The Cash Management Improvement Act of 1990 (CMIA) provides rules and procedures for the efficient transfer of federal financial assistance between the federal agencies and the State

Center for Medicare and Medicaid Innovation (CMMI): Part of CMS; supports the development and testing of innovative health care payment and service delivery models

Centers for Medicare and Medicaid Services (CMS): A federal agency within the United States Department of Health and Human Services (DHHS).

Certified Professional Coder (CPC): A Certification granted by the AAPC. See http://www.aapc.com/certification/cpc.aspx

Change System Request (CSR): also known as a **System Modification Authorization**

Chief Information Officer (CIO): The State position overseeing the Department of Information and Innovation

Chief Technology Officer (CTO): The State position within DII in charge of technology strategy and implementation

Clawback: The mechanism through which the states will help finance the new Medicare drug benefit is popularly known as the "clawback" (the statutory term is "phased-down State contribution").

Coordination of Benefits: allows plans that provide health and/or prescription coverage for a person with Medicare or any other insurance to determine their respective payment responsibilities (i.e., determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan).

Coordination of Benefits Unit (COB): a unit of DVHA responsible for coordinating benefits across payers to ensure Medicaid is the payer of last resort. COB activities include but are not limited to, estate recovery, casualty recovery, and HIPP

Collaborative Application Lifecycle Tool (CALT): CALT is a collaborative tool that creates a centralized repository for storing, collaborating on and sharing deliverables and artifacts from IT projects in support of Medicaid administration and establishment of Exchanges

Commercial Off-The-Shelf (COTS): Ready-made software applications

Common Enterprise Portal: Enterprise portals are a type of composite application that pre-integrates the services needed to build contextual websites

Community Rehabilitation and Treatment (CRT): Vermont's Community Rehabilitation and Treatment programs assist adults that have been diagnosed with a mental illness. Symptoms may be mild or substantially disabling, and long-term or short term.

Contract: Binding agreement between the State of Vermont and the awarded Vendor.

Current Procedural Terminology: (CPT): CPT® is a trademark of the American Medical Association

Customers: Providers, Members, AHS and other System users

Customer Support Representative (CSR): Customer-facing service representatives employed by the State or by a partner Vendor, please note in this document CSR can also mean Change System Request

D

Dashboards: Display Key Performance Indicators (KPIs) or business metrics using intuitive visualization, including dials, gauges and traffic lights that indicate the state of various KPIs against targets

Data Mart: Analytical data stores, usually part of a data warehouse, that are designed to focus on specific business functions for a specific community within an organization

Data Mining: The process of discovering meaningful correlations, patterns and trends by sifting through large amounts of data stored in repositories

Data Sharing: Refers to the collaboration functionality (e.g., search, data exchange, communication mechanisms) or the work stream containing that functionality

Data Warehouse: A repository of an organization's electronically stored data, designed to facilitate reporting and analysis

Database Management System (DBMS): A set of computer programs that control the creation, maintenance, and the use of a database

Deliverable Expectations Document (DED): A document approved by the State to guide the development of deliverables created by a Vendor

Department for Children and Families (DCF): The State's eligibility and enrollment for Medicaid and all public assistance programs are administered by DCF including but not limited to, 3SquaresVT (SNAP), Reach Up (TANF) and General Assistance

Department of Corrections (DOC): A department within AHS charged with overseeing the state correctional facilities, supervising probation and parolees, and serving in an advisory capacity in the prevention of crime and delinquency

Department of Disabilities, Aging and Independent Living (DAIL): A department within AHS responsible for all facility-based and community-based long-term care services for older Vermonters, individuals with developmental disabilities, traumatic brain injuries, and physical disabilities

Department of Health and Human Services (DHHS): The Department of Health and Human Services is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves

Department of Information and Innovation (DII): The State department overseeing technology and technology implementations

Department of Mental Health (DMH): DMH administers mental health programs across the State through multiple programs for both adult and children's services, including but not limited to CRT, Child, Adolescent and Family Mental Health Services and Enhanced Family Treatment

Department of Vermont Health Access (DVHA): DVHA administers nearly all of the publically funded health care programs for the State of Vermont

Design, Development and Implementation (DII): The common term for the project based work to stand up technology and/or services

Designated Agency (DA): Private, non-profit service providers called located throughout the state. The Department of Mental Health designates one Designated Agency (DA) in each geographic region of the state as responsible for ensuring needed services are available through local planning, service coordination, and monitoring outcomes within their region.

Diagnosis Related Group (DRG): A statistical system of classifying any inpatient stay into groups for the purposes of payment.

Disproportionate Share Hospital (DSH): The Medicare DSH adjustment provision under section 1886(d) (5) (F) of the Act was enacted by section 9105 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 and became effective for discharges occurring on or after May 1, 1986.

Designated State Health Program (DSHP): Programs approved to be DSHPs funded by Medicaid funds

Distributed Query: This query provides the ability to access data from multiple heterogeneous data sources. These data sources can be stored on either the same or different computers

Dual Eligible: A member with both Medicare and Medicaid

E

Early Periodic Screening, Diagnosis, and Treatment (EPSDT): services to achieve proper growth and development or prevent the onset or worsening of a health condition provided by the State for any child under 21 years of age eligible under the State plan in a category under section 1902(a)(10)(A) of the Act.

Edit: Edit verifies information on a single claim based on accuracy, validity, required presence of allowable values, and integrity of data submitted

Electronic Funds Transfer (EFT): The electronic transfer of funds

Electronic Medical Record (EMR): A software package that electronically manages the storage and retrieval of medical records

Employer-Sponsored Insurance Premium-Assistance Program: (ESIA)

Engineering Change Requests (ECR): Requests for systems changes

Enrolled Provider: an individual, group, company or business under contract with the State to deliver a service(s) or product

Enterprise Architecture (EA): The competency of integrating business, information, application and technology to a cohesive goal

Enterprise Project Management Office (EPMO): Part of DII; The State oversight project management office

Enterprise Service Bus (ESB): A software construct found in a Service-Oriented Architecture that provides fundamental services via a messaging engine

Extract, Transform, Load (ETL): A process for transitioning data from one system to another.

External Quality Review Organization: EQEO, Federal regulations require that states which contract with Medicaid Managed Care Organizations (MCO) or Prepaid Inpatient Health Plans (PIHP) conduct an External Quality Review (EQR) of each entity. States may perform EQR tasks directly, or may contract with independent entities called External Quality Review Organizations (EQRO) to conduct the external quality review.

Extraction, Transformation, and Load (ETL) Tools: Tools that extract data from outside databases, transform the data to a usable form and load it into a target database

F

- **Fair Hearing, Grievance , Appeal:** Fair Hearing, Grievance, Appeal, CFR §438.400 Statutory basis and definitions and §431.200 Basis and scope

  CFR §438.400 Statutory basis and definitions

  Appeal means a request for review of an action, as "action" is defined in this section.

  Grievance means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

  §431.200 Basis and scope.

  Fair Hearing: (b) Prescribes procedures for an opportunity for a hearing if the State agency or PAHP takes action, as stated in this subpart, to suspend, terminate, or reduce services, or an MCO or PIHP takes action under subpart F of part 438 of this chapter; and

Financial Budget Report (FBR): A financial budgeting and tracking tool

Federal Employer Identification Number: FEIN, An Employer Identification Number or EIN is the corporate equivalent to a Social Security Number, although it is issued to anyone, including individuals, who have to pay withholding taxes on employees

Federal Data Hub: A data services hub to help states verify the income, citizenship and other information about individuals when they seek health coverage through health insurance exchanges and for Medicaid and Children's Health Insurance Programs

Federal Financial Participation (FFP): The rate and amount the Federal government provides for Medicaid activities within the State

Federal Information Security Management Act (FISMA): The Federal Information Security Management Act of 2002 ("FISMA", 44 U.S.C. § 3541, et seq.)

Federally Qualified Health Centers (FQHC): Federally designated health organizations that provide health care regardless of a person's ability to pay

Fee-for-Service (FFS): A reimbursement methodology used in health care

Fiscal Agent (FA): The services the Vendor is expected to provide that supports the claiming and fiscal matters on behalf of the State. The Vendor is expected to be the auditable source for the finances of the State.

File Transfer Protocol (FTP): A standard network protocol used to copy a file from one host to another

Firewall: A technological barrier designed to prevent unauthorized or unwanted communications between computer networks or hosts

Frequently Asked Questions (FAQ): Lists of commonly asked questions and their answers

G

Geographic Information System (GIS): A system that processes geographic information such as mapping of geographic points or areas or using mathematical algorithms for measuring distance

Global Commitment to Health Waiver: As part of the State Fiscal Year 2006 budget proposal process, the Douglas Administration presented the Plan for Saving the Vermont Medicaid System. With this long-term strategy Vermont proposed to replace its existing section 1115a waiver, the Vermont Health Access Plan (VHAP). The replacement is the Global Commitment to

Health. With the Federal approval of this proposal, certain Federal Medicaid requirements found in Title 19 of the Social Security Act are waived. The result is that the Global Commitment to Health includes the tools necessary for the state, in partnership with the Federal government, to address future needs in a holistic, global manner.

Government Accounting Office (GAO): A Federal office initially charge to investigate, at the seat of government or elsewhere, all matters relating to the receipt, disbursement, and application of public funds, and shall make to the President ... and to Congress ... reports [and] recommendations looking to greater economy or efficiency in public expenditures

Green Mountain Care Board: (GMCB): Created by the Vermont Legislature in 2011, GMCB is an independent group of five Vermonters who, with their staff, are charged with ensuring that changes in the health system improve quality while stabilizing costs.

H

Health and Human Services (HHS): The general term used to describe services provided by AHS

Health Benefits Exchange (HBE): Vermont's implementation of the Health Insurance Marketplace, entitled Vermont Health Connect

Healthcare Common Procedure Coding System (HCPCS): A nationally known and used health care coding system

Healthcare Effectiveness Data and Information Set (HEDIS): The Healthcare Effectiveness Data and Information Set is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 75 measures across 8 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis.

Health Information Exchange (HIE): Vermont's HIE is Vermont Information Technology Leaders

Health Insurance Portability & Accountability Act (HIPAA): A Federal act that requires specific controls for the use and sharing of data and information

Health Insurance Marketplace (HIM): Vermont's implementation of the Health Insurance Marketplace is entitled Vermont Health Connect

Health Insurance Premium Program (HIPP): A Medicaid program that provides premium assistance for a Medicaid beneficiary to enroll or remain enrolled in a private health insurance plan, if the Medicaid program finds it to be cost-effective for the program. The Omnibus Budget Reconciliation Act of 1990 (OBRA-90) authorized states to implement a HIPP program.

Health Information Technology (HIT): The general term for technology used in support of healthcare

Health Services Enterprise (HSE): The overreaching program structure that governs the HIX, the IE solution, the MSE and the HSE Platform.

Hewlett-Packard (HP): The current MMIS and Fiscal Agent vendor. This usage may also refer to Hewlett Packard Enterprise Services (HPES), a division of HP

Health Information Technology for Economic and Clinical Health Act (HITECH): The Health Information Technology for Economic and Clinical Health Act was enacted under Title XIII of the American Recovery and Reinvestment Act of 2009 (Pub.L. 111–5). Under the HITECH Act, the United States Department of Health and Human Services is spending $25.9 billion to promote and expand the adoption of health information technology

Home and Community-based Services (HCBS): Specific services approved by AHS that promotes care in the home and community

Health Services Enterprise Platform: HSE Platform, "the Platform", The shared services and infrastructure that will be shared across solutions.

I

Identification (ID): Identification

Identity and Access Management (IAM): The management of individual IDs, their authentication, authorization, and privileges/permissions within or across system and enterprise boundaries

Ineligible: an individual does not qualify for Public Assistance at either initial or subsequent re-determination

Information Architecture: A description of the information and data flows that are critical to a solution. This architecture illustrates the types of information and data that are collected by a solution and how the information is aggregated, stored, and used for reporting purposes

Information Systems Division (ISD): A division within DCF

Institute of Electrical and Electronics Engineers (IEEE): A standards organization

Integrated Eligibility: (IE): may refer to Vermont's Integrated Eligibility System, the functionality associated with the process of determining eligibility for multiple programs through the use of a single application or the work stream containing that functionality

Interface: A point of interaction between two systems or modules

Interagency Agreement (IGA): An agreement between two government agencies

Internal Control Number (ICN): An identification number for processing purposes

International Standards Organization (ISO): A standards organization

Intrusion Detection System (IDS): A device (or application) that monitors network and/or system activities for malicious activities or policy violations and produces reports to a Management Station

Independent Verification and Validation (IV&V): Third party that oversees the project to ensure quality and timely delivery.

Interactive Voice Response System (IVRS): A telephony system that provides interactive, logic-based choices for callers to route them to the appropriate Customer Service Representatives

J

Joint Application Development (JAD): A process for the development of requirements commonly used in systems development

K

L

Lock-in: The act of restricting a Member's access to certain programs, services and/or Providers

M

Maintenance & Operations (M&O): A phase of a systems project that consists or maintenance and operations of those systems

Managed Care Organization (MCO): An organization that an organization that combines the functions of health insurance, delivery of care, and administration

Management Reporting System (MRP): A system for management reporting

Maximum Acquisition Cost (MAC): A federally set maximum cost

Medicaid: Provides low-cost or free health coverage and supports for individuals with low-income: children, young adults under age 21, parents, pregnant women, caretaker relatives, people who are aged, blind or disabled

Medicaid Information Technology Architecture: MITA, MITA is a reference business, information and technology architecture developed to support Medicaid across the country. Additional details can be found at: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Medicaid-Information-Technology-architecture-MITA.html

Medicaid Management Information System (MMIS): The primary claiming and payment system for a Medicaid agency

Medicaid Operations Services: Operational support services for Medicaid and AHS operations in Vermont which includes design, development and implementation services, ongoing maintenance and operation support, and Fiscal Agent / financial support services

Medical Assistance Provider Incentive Repository (MAPIR): MAPIR refers to the state-level information system that currently supports the electronic health record incentive program. MAPIR will track and act as a repository for information related to payment, applications, attestations, oversight functions, and interface with CMS' National Level Repository.

Member: An individual eligible and enrolled in one or more state benefits plan

Memorandum of Understanding (MOU): An agreement between two parties

Metadata: Information that describes various facets of an information asset to improve its usability throughout its life cycle

Master Data Management (MDM): The competency of managing data that promotes data quality and consistency

Middleware: Computer software that connects software components or applications. The software consists of a set of services that allows multiple processes running on one or more machines to interact

Modified Adjusted Gross Income (MAGI): The basis for Medicaid expansion eligibility determination and a defined Internal Revenue Service term

Module: A portion of a system that provides specific, discrete functionality

N

Neuro-Linguistic Programming (NLP): An ontology-assisted way of programming in terms of natural language sentence

National Committee for Quality Assurance (NCQA): The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

National Council for Prescription Drug Programs (NCPDP): Not-for-profit, ANSI-accredited, standards development organization that provides healthcare business solutions through education and standards.

National Drug Code: NDC, National Drug Code (NDC) is a numerical code maintained by the FDA that includes the labeler code, product code, and package code. The NDC is an 11-digit code.

National Information Exchange Model (NIEM): An XML-based information exchange framework from the United States representing a collaborative partnership of agencies and organizations across all levels of government (federal, state, tribal, and local) and with private industry

National Institutes of Standards and Technology (NIST): A standards organization

National Plan & Provider Enumeration System: The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers

National Provider Identifier: The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).

Non-Functional Requirement (NFR): Requirements that are not classified as Functional Requirements

O

Online Analytical Processing (OLAP): Client and server based analysis tools, allowing for complex analytical and ad-hoc queries with a rapid execution time

Online Transaction Processing (OLTP): Systems that facilitate and manage transaction-oriented applications, typically for data entry and retrieval transaction processing

Open Source: Practices in production and development that promote access to the end product's source materials or code

Operational Data Store (ODS): A database designed to integrate data from multiple sources to make analysis and reporting easier

P

Pay and Chase: pay-and-chase occurs when States pay providers for submitted claims and then attempt to recover payments from liable third parties. States may pay and chase claims for two primary reasons: postpayment identification of TPL and Social Security Act exceptions to cost avoidance

Person-centric approach: An approach centered around the client and focused on delivering services to achieve an outcome

Pharmacy Benefits Management (PBM)

Point-of-Sale (POS): The combination of services and technology available to process a medical claim or pharmacy claim in “real time”

Portal: A computing gateway that unifies access to enterprise information and applications

Primary Care Provider (PCP) A health care practitioner who treats illnesses, provides preventive care, and coordinates the care provided by other health professionals.A PCP is usually a doctor, but may be a physician’s assistant or a nurse practitioner

Primary Case Management (PCCM): A system of managed care used by state Medicaid agencies in which a primary care provider is responsible for approving and monitoring the care of enrolled Medicaid Members, typically for a small monthly case management fee in addition to fee-for-service reimbursement for treatment

Prior Authorization (PA): a process used to assure the appropriate use of health care services. It involves a request for approval of each health service that is designated as requiring prior approval before the service is rendered.

Process Flows: A diagram depicting the set of activities required to perform a specific function in the future state

Program Integrity (PI): The Affordable Care Act includes numerous provisions designed to increase program integrity in Medicaid, including terminating providers from Medicaid that have been terminated in other programs, suspending Medicaid payments based on pending investigations of credible allegations of fraud, and preventing inappropriate payment of claims under Medicaid

Project Information Library: A comprehensive collection of project documentation

Project Management Body of Knowledge (PMBOK): A comprehensive knowledge center developed and maintained by the Project Management Institute

Project Management Institute (PMI): A certifying agency that specializing in project management. The PMI is a not-for-profit professional membership association for the project, program and portfolio management profession.

Project Management Office (PMO): An organization that manages projects

Project Management Plan (PMP): A comprehensive plan for the execution of a project; includes multiple sub-plans that address specific project management aspects

Proposal: An offer from the State requesting specific services to a prospective Vendor

Provider: an individual, group, company or business that supplies a service(s) or product

Q

Quality Assurance (QA): a program for the systematic monitoring and evaluation of the various aspects of a project, service, or facility to ensure that standards of quality are being met

R

Relational Database Management System (RDBMS): A Database Management System in which data is stored in the form of tables and the relationship among the data is also stored in the form of tables

Regional Health Information Organization (RHIO): A regionally-based organization that promotes information exchange and technology adoption

Reach Up: Reach Up is the implementation of TANF in Vermont; it helps families with children by providing cash assistance for basic needs and services that support work and self-sufficiency

Remittance Advice (RA): Documentation of remittances issues to payment recipients

Requirements: Detailed list of requirements necessary for the proposed solution

Requirements Traceability Matrix (RTM): A detailed list of requirements, along with their source, that tracks the functionality and other requirements a system needs to provide

Request for Proposal (RFP): A document that details the proposal that a vendor must submit to an issuer

Rich Internet Application (RIA): Web application that has many of the characteristics of a desktop application, typically delivered either by way of a site-specific browser or via a browser plug-in

S

Service Level Agreement (SLA): An agreement between two parties of the level of service one will provide to the other

Service-Oriented Architecture (SOA): A set of design principles used in application development characterized by the following attributes:

1. The system must be modular. This provides the obvious benefit of being able to "divide and conquer" — to solve a complex problem by assembling a set of small, simple components that work together
2. The modules must be distributable — that is, able to run on disparate computers and communicate with each other by sending messages over a network at runtime
3. Module interfaces must be "discoverable" — that is, clearly defined and documented. Software developers write or generate interface metadata that specifies an explicit contract, so that another developer can find and use the service
4. A module that implements a service must be "swappable." This implies that it can be replaced by another module that offers the same service without disrupting modules that used the previous module. This is accomplished by separating the interface design from the module that implements the service
5. Service provider modules must be shareable — that is, designed and deployed in a manner that enables them to be invoked successively by disparate applications in support of diverse business activities

Seven Conditions and Standards: CMS published guidance entitled *The Seven Conditions & Standards for Enhanced Funding*, which lists requirements that states must meet to leverage the 100%, 90/10, and other federally matched funding streams that support the ACA. The Seven

Standards serve as a touchstone for the modular, flexible, interoperable design of the Health Services Enterprise and its emphasis on reusability of portfolio components.

Shared Analytics Infrastructure (SAI): Infrastructure established to provide shared analytics among systems

Shared Analytics: Refers to the business intelligence functionality or the work stream containing that functionality

Shared Savings Plan (SSP): A CMS established program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs

Simple Object Access Protocol (SOAP): A protocol specification for exchanging structured information in the implementation of Web Services

Supplemental Nutrition Assistance Program (SNAP): A program that offers nutrition assistance to eligible, low-income individuals and families and provides economic benefits to communities. SNAP is the largest program in the domestic hunger safety net. Vermont's SNAP program is referred to as 3SquaresVT

Social Security Administration (SSA): Delivers services through a nationwide network of over 1,400 offices that include regional offices, field offices, card centers, teleservice centers, processing centers, hearing offices, the Appeals Council, and our State and territorial partners, the Disability Determination Services

Social Security Number (SSN): A nine-digit number assigned to citizens, some temporary residents and permanent residents in order to track their income and determine benefit entitlements

Supplemental Security Income (SSI): a program through the Social Security Administration that pays benefits to disabled adults and children; with limited income and resources.

Social Services Management Information System (SSMIS): System for the management services in the Department for Children and Families, Family Services Division

Software as a Service (SaaS): Software that is developed to be delivered as a service. The software and supporting infrastructure are owned, delivered and managed remotely by an external provider

Software Development Kit (SDK): A set of development tools that allows for the creation of applications for a certain software package

Software Development Lifecycle (SDLC): A common framework for systems development

Software Engineering Institute (SEI): The Carnegie Mellon Software Engineering Institute (SEI) works closely with defense and government organizations, industry, and academia to continually improve software-intensive systems. Our core purpose is to help organizations such as yours to improve their software engineering capabilities and to develop or acquire the right software, defect free, within budget and on time, every time

Solution: A combination of system(s) and services that meet the needs of the documented functional and non-functional requirements in the context of the goals and objectives of AHS, as detailed in this RFP

Solution Architecture: A holistic description of a solution comprised of business architecture, information architecture, and technology architecture views

Stakeholder: A stakeholder is anybody who can affect or is affected by an organization, strategy or project

State Children's Health Insurance Program (SCHIP): See CHIP

State Innovation Model (SIM): The State Innovation Models Initiative is providing up to $300 million to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states. Projects are broad based and focus on people enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP). In Vermont this is referred to as the Vermont Healthcare Innovation Project (VHCIP)

State Medicaid Agency (SMA): The single agency within a state that manages the Medicaid program for that state

State of Vermont ("State", "the State" or "Vermont"): The State issuing this RFP

Subject Matter Expert (SME): An expert in a specific subject area

Success Beyond Six: The Agency of Human Services and the Agency of Education established a Success Beyond Six Legislative Study Group to help respond to the legislative charge from the 2007 sessions' appropriation bill. The work group was made up of individuals from various mental health and education perspectives. The charge from the legislature was to ensure that expenditures through the Success Beyond Six funding mechanism: Utilize best practices; Yield positive outcomes; and Are managed to a predictable rate of growth.

Surveillance and Utilization Review Subsystem: SURS, MMIS subsystem which applies automated post-payment screens to Medicaid claims adjudication to identify aberrant billing patterns, which may be fraud or provider abuse

System: A combination of software, applications (e.g. claims processing application, provider management application), and technology infrastructure. This term may address the MMIS, Contact Center, or other systems described in this RFP.

System Level Requirements (SLR): Service-based requirements that a Vendor is expected to meet

System Modification Authorization (SMA): An authorization to make a change to a system

T

Temporary Assistance for Needy Families (TANF): One of the United States of America's federal assistance programs. It began on July 1, 1997, and succeeded the Aid to Families with Dependent Children (AFDC) program, providing cash assistance to indigent American families with dependent children through the United States Department of Health and Human Services. Vermont's TANF program is referred to as Reach Up.

Technology Architecture: The technical layer on which a solution is based. The technical architecture is comprised of all the major hardware and software technology entities required to enable the solution to meet the business and information requirements

Technical Design Document (TDD): The proposed and agreed-upon document that details the technology design of a system

Third Party Liability (TPL): The legal liability of third parties to pay for services provided under the plan; assignment to the State of an individual's rights to third party payments; and cooperative agreements between the Medicaid agency and other entities for obtaining third party payments

Training of Trainers (ToT): The activity of training those that will train others

U

Use Case: A format used to capture the requirements from a client and user perspective. The purpose of the use cases is to illustrate *what* the system is expected to do, not *how* it is expected to do it.

User Acceptance Test (UAT): Testing by users with the intent of acceptance of a system by the client

User Interface (UI): The method or component users use to interact with a system

V

VISION: (Vermont Integrated Solution for Information and Organizational Needs) is an Oracle/PeopleSoft enterprise financial management system also administered by the Department of Budget and Management

Vendor: Systems Integrator that is awarded the contract to provide the solution

Verification Agency: Includes licensing, credentialing, authorization, and exclusionary authorities.

Vermont Chronic Care Initiative (VCCI): A Health Care Reform strategy for Medicaid that provide targeted care management for a subset of the Vermont population

Vermont Department of Health (VDH): the state's lead agency for public health policy and advocacy.

Vermont Information Technology Leaders (VITL): VITL is a 501(c)(3) non-profit organization that assists Vermont health care providers with adopting and using health information technology to

improve patient care. VITL began as a project of the Vermont Association of Hospitals and Health Systems and was spun off as a separate entity in July 2005

Vermont Health Access Plan (VHAP) is a health insurance program for adults age 18 and older who meet income guidelines. This program ended on March 31, 2014 due to the implementation of the ACA.

Vermont Health Connect (VHC): Vermont's implementation of a health insurance marketplace, also commonly referred to as the Health Benefits Exchange

Vermont Health Information Technology Plan: Vermont Health Information Technology Plan (VHITP) is the operational planning document that contains the Health Information Technology (HIT) and Health Reform Information Technology systems

Vermont Healthcare Innovation Project (VHCIP): Vermont's implementation of the State Innovation Model

Virtual Private Network (VPN): A network that uses a public telecommunication infrastructure, such as the Internet, to provide remote offices or individual users with secure access to their organization's network

Vermont Integrated Solution for Information and Organizational Needs (VISION): State of Vermont's financial system and is an Oracle / PeopleSoft enterprise financial management system

VPHARM: Assists Vermonters who are enrolled in Medicare Part D with paying for prescription medicines. This includes people age 65 and older as well as people of all ages with disabilities up to 225% of the federal poverty level (FPL).

W

Web 2.0: This term describes Web applications that facilitate interactive information sharing, interoperability, user-centered design, and collaboration on the World Wide Web. Examples include wikis, blogs, and mashups

Web Service Specifications: Collectively referred to as "WS-*" and pronounced "w-s-star." These are industry-supported standards that provide the heterogeneity and interoperability that applications require

Web Services: Web services are modular business services delivered over the Internet as and when needed. The modules can be combined, can come from any source, and can eventually be acquired dynamically and without human intervention, when needed. They are a key building block of a Service-Oriented Architecture

Web Services Description Language (WSDL): An XML-based language that provides a model for describing Web Services

Wide Area Network (WAN): A computer network that covers a broad area (i.e., any network whose communications links cross metropolitan, regional, or national boundaries)

Work: "The Work" in this RFP is defined as project services and ongoing operational and hosting services.

Work Breakdown Structure: WBS

X

XML (Extensible Markup Language): A language similar to HTML that allows for the self-descriptive categorization, storage and transport of data

Y

Z